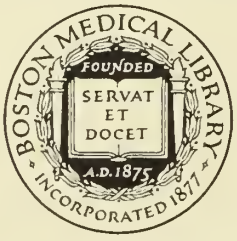
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JANUARY 1972
VOL. 68 NO. 1

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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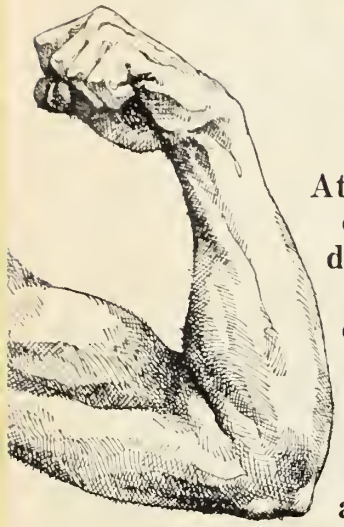
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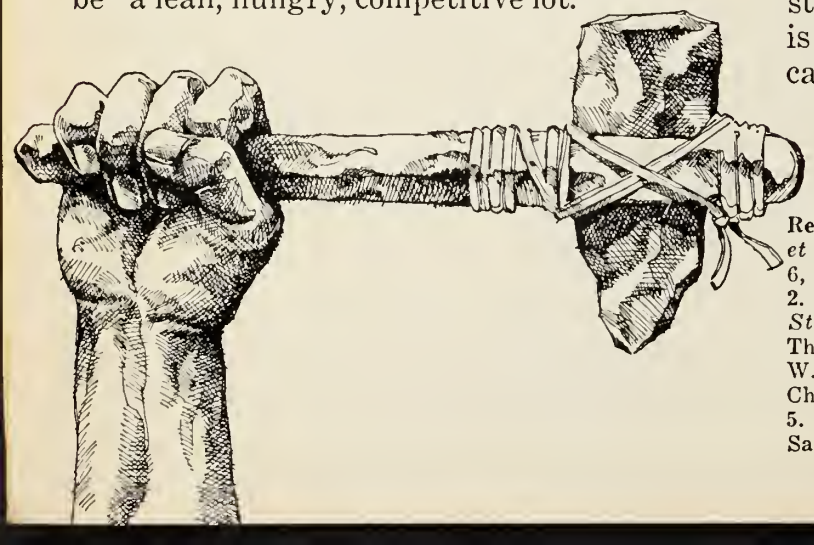
IF MORE MEN CRIED



At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.



Take away stress, you can take away symptoms. There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

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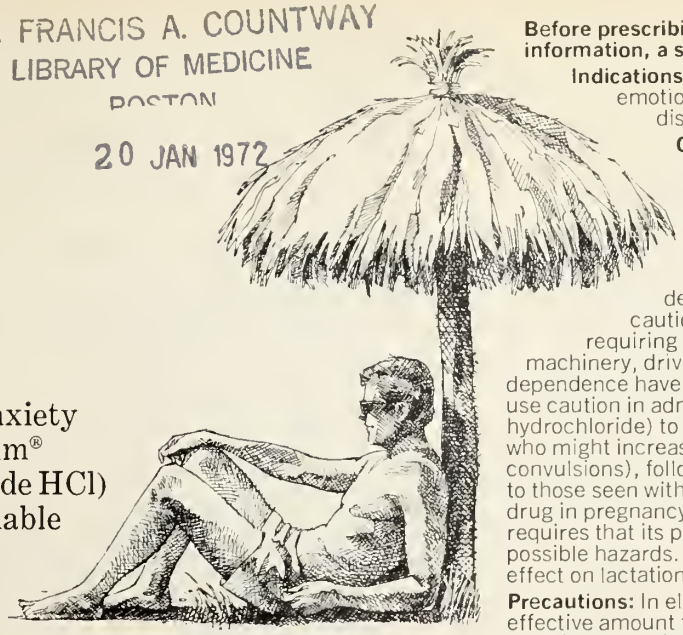
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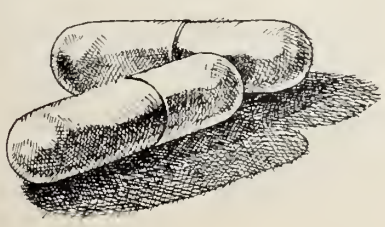


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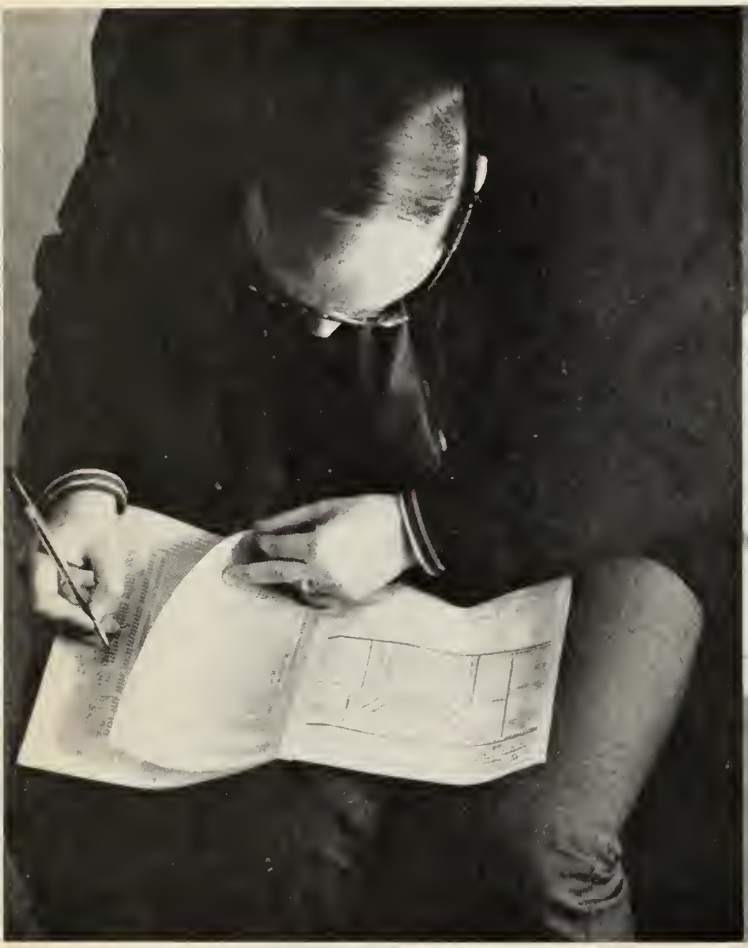
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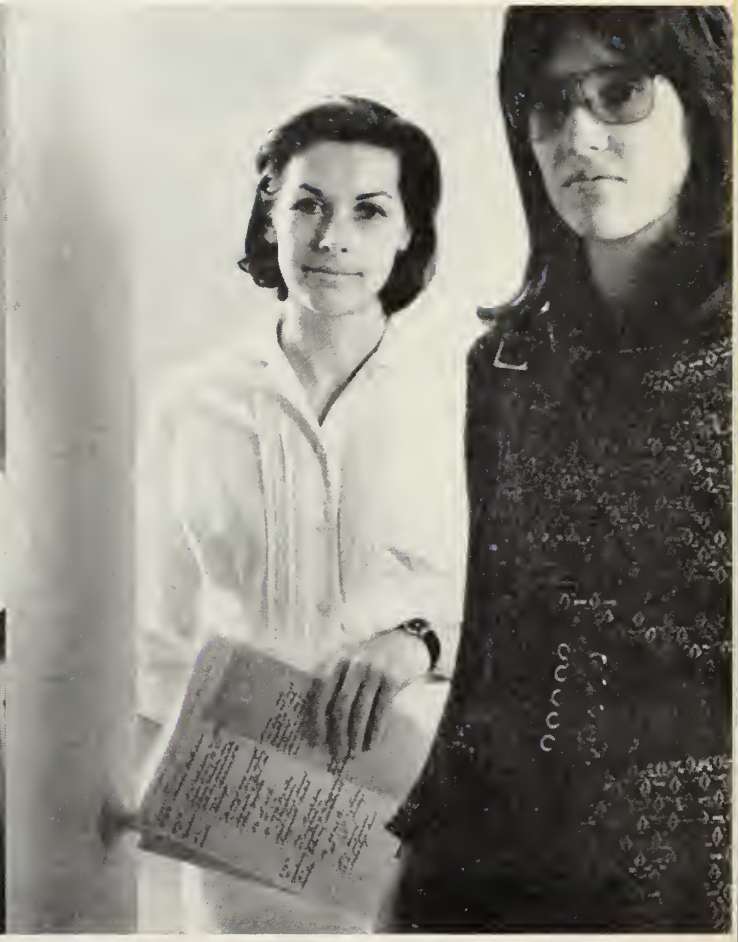
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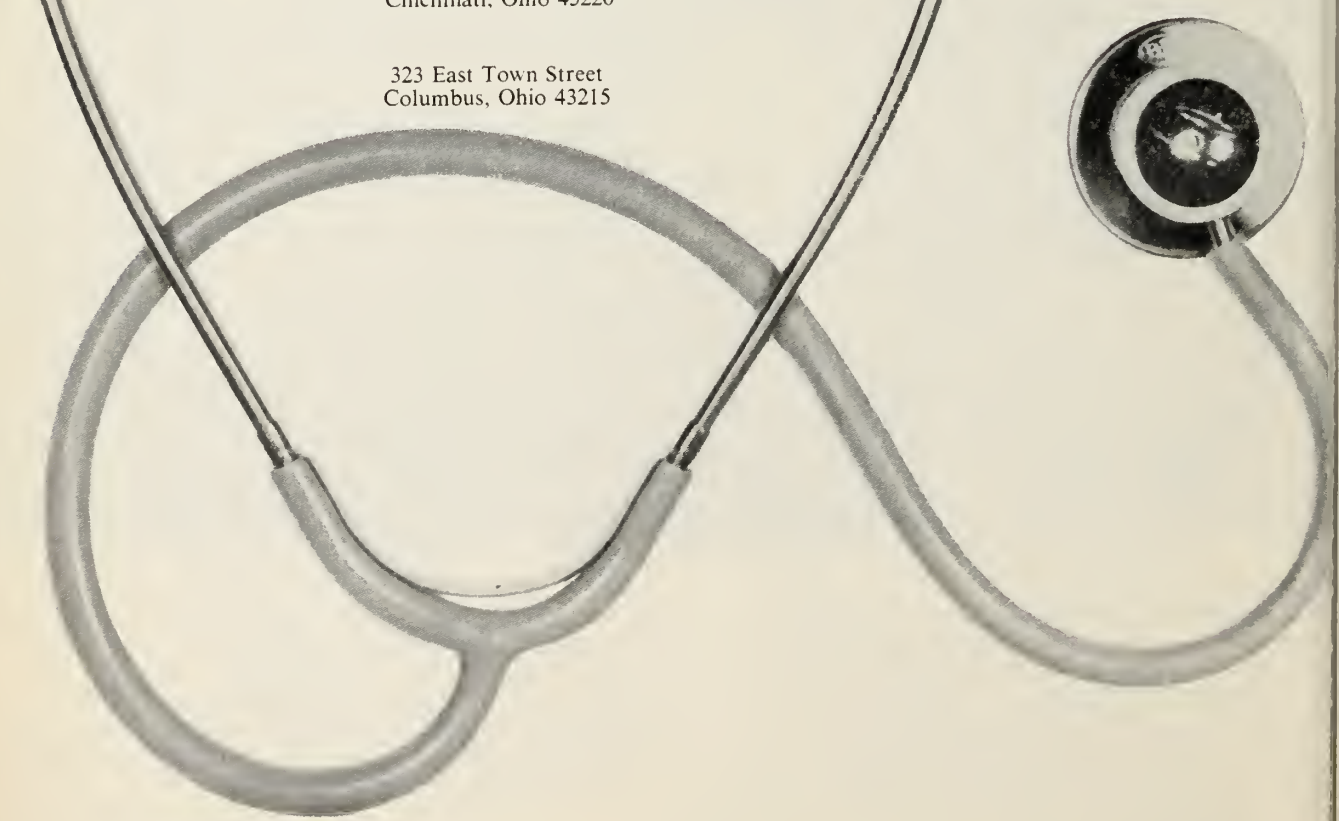
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Roles of the Joint Advisory Committee and the Section on Sports Medicine

By Thomas E. Shaffer, M.D.

IMAGINE, IF YOU WILL, an ear-shattering roar from thousands of Romans jammed into the Coliseum in about 180 AD. A favorite gladiator of Emperor Marcus Aurelius has downed a stubborn opponent. However, numerous cuts and bruises are visible as the weary fighter accepts the cheers of the crowd. There's little doubt that he needs medical attention before returning to the arena to further entertain the powerful emperor and his subjects.

Medical attention he gets—and from none other than Galen, the celebrated physician who was born in Greece and later moved to Rome to become the personal physician of Marcus Aurelius.

This historical tidbit simply illustrates that the practice of sports medicine has been around longer than many of us would suspect. However, we Americans did not become involved in this effort until after Thorndike's book on athletic injuries was published in 1938. Yes, 1938! In my state of Ohio where we take our sports quite seriously, sports medicine programs didn't begin on a major scale until 1957—almost 18 centuries after Galen provided coverage at the Coliseum. But, we've come a long way in only a few years.

In a paper presented at the AMA's Second National Conference on the Medical Aspects of Sports in November, 1960, we discussed a highly successful, one-day conference for coaches, athletic trainers, school administrators and team physicians sponsored by the Montgomery County (Dayton and vicinity) Medical Society in August, 1957. The program covered several aspects of the prevention and treatment of athletic injuries. A similar conference, also hailed as a success, was held in Lorain County (near Cleveland) in 1958.

Dr. Shaffer is director of Adolescent Services for Children's Hospital, Columbus, and professor, Department of Pediatrics, Ohio State University College of Medicine. He is chairman of the AMA Committee on the Medical Aspects of Sports, a member of the OSMA Committee on School Health, and an OSMA member of the Joint (Ohio) Committee on Sports Medicine.

This paper was presented during the 13th National Conference on Medical Aspects of Sports, held in New Orleans on November 28 in connection with the AMA Clinical Convention.

Hits Responsive Chord

The tidings of these successful conferences soon spread. In 1959 the House of Delegates of the Ohio State Medical Association instructed the Committee on School Health to seek establishment of "all possible safeguards for the health and safety of high school athletes." The Committee on School Health promptly met with representatives of the Ohio High School Athletic Association. This meeting produced several proposals which were soon adopted by The Council of the Ohio State Medical Association. The proposals included:

- That a joint advisory committee on athletic injuries be established with membership from both organizations.
- That county medical societies be encouraged to make certain that a physician be in attendance at all football games either as school employee or volunteer.
- That the Ohio State Medical Association and Ohio High School Athletic Association together develop educational programs in prevention of athletic injuries, for meetings of officials, athletic trainers, coaches and others.

Thus was born the Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and Ohio High School Athletic Association.

This group sponsored a two-day Postgraduate Institute for Physicians on Medical Aspects of High School Athletics, in 1960, with the cooperation of the Ohio State University College of Medicine. Approximately 85 physicians, some from other states, learned about a variety of topics including responsibilities of the athletic coach in handling injuries, conditioning, neurological problems and protective equipment.

The 1960 Postgraduate Institute was a springboard for similar conferences for physicians in 1962, 1964 and 1967. Meetings in 1969 and 1970 were held in conjunction with the Annual Meeting of the Ohio State Medical Association. Also, several conferences have been held on a regional

basis for coaches, athletic trainers, physical education instructors and school administrators.

A Broader Scope

In 1970 we changed the last two words of our Joint Advisory Committee's title from Athletic Injuries to **Sports Medicine** — for the obvious reason that sports medicine covers a much broader scope than that of trauma, only.

Also in 1970 the Council of the Ohio State Medical Association approved our request for a Scientific Section on Sports Medicine. This was recommended in order to bring together in cooperative effort those physicians — in general practice and the many specialties — who have common interest in the medical aspects of sports.

The Section on Sports Medicine will convene once a year during the OSMA Annual Meeting. The first meeting in May, 1971, attracted a crowd of more than 250 persons, including laymen as well as physicians. It was memorable for two reasons; the first being that women played a prominent role. A female physical education instructor from an Ohio high school presented "Myths About the Miss In Sports." Two lovely ladies — one a high school physical education instructor and the other a student majoring in physical education at Ohio State University — participated on a panel concerning physical fitness.

After wowing the crowd with the ladies, we brought on W. W. "Woody" Hayes to discuss the role of sports medicine with his football team at Ohio State University. Woody made a hit with everyone except the custodial staff and security people at the auditorium. They were upset because Woody concluded his program about one hour after the auditorium was scheduled to be locked and secured.

Goals

Now let's take a look at the goals of the Joint Advisory Committee on Sports Medicine — and some of the ways by which the Committee hopes to attain these goals.

The primary goal is still the same as when the Committee was formed in 1959; that is TO PROMOTE THE HEALTH AND SAFETY OF YOUNG ATHLETES.

Many of you are familiar with *Safeguarding the Health of the Athlete* published by the AMA Committee on the Medical Aspects of Sports and the National Federation of State High School Athletic Associations. We have stressed five major factors in the health supervision of athletes emphasized in this publication. These factors are guidelines in the function of our Joint Advisory Committee:

Proper conditioning, careful coaching, good officiating, top-grade equipment and facilities, and adequate medical care.

Five seems to be the magic number today — because there are five primary programs or activities through which the Joint Advisory Committee on Sports Medicine functions to serve its primary purpose. In brief, these goals are as follows:

1. Postgraduate education for physicians interested in sports medicine.

2. Postgraduate education for coaches, athletic trainers, officials, physical education instructors and school administrators.

3. Recommendations to the OSMA Council.

4. Consultation to the Board of Control of the Ohio High School Athletic Association.

5. Public information, team physician placement and liaison functions.

The 1972 Scientific Section on Sports Medicine, coming up next May, will live up to its title of being a *scientific* gathering for physicians. Among the topics now on the drawing board are physiology and pathology of serious injury or death by environmental heat, effect of isometric muscular contraction on blood pressure, physiological effect of specific nutrients and/or vitamins in the athlete, and oxygen utilization.

Roster of Interested Physicians

Last year the OSMA headquarters staff updated a statewide roster of physicians — both MD and DO — interested in sports medicine. This was accomplished by a questionnaire included in an issue of the *OSMAgram,* the newsletter published approximately every two months for all OSMA members. The Ohio Osteopathic Association also carried the form in its publication. About 400 responded to the survey. Occasional mailings concerning activities of the Section and other sports medicine items of general interest have gone to this group from time to time.

Also, upon request, the staff furnishes a packet of sports medicine information to physicians — especially those who are new team physicians.

The Joint Advisory Committee plans to revive the Postgraduate Institutes held in the sixties. A late summer meeting would allow on-site experiences such as a visit to the training room, observations at the practice field of the Ohio State University football team during preseason

preparation and personal association with coaches and athletic trainers.

Let's look now at the activities in postgraduate education for those not in the medical profession.

A most significant resolution concerning environmental heat and athletics was adopted by the OSMA House of Delegates in 1965. It called for preseason conditioning, medical leadership in the education of coaching staffs and direct supervision by medical societies of personnel who assess the heat and humidity on the playing field. This resolution also called for changes in or postponement of practice sessions or games in the event of extreme conditions of heat and humidity.

Dr. Robert J. Murphy, of Columbus, is on our program here at this conference today. He has been the leader in Ohio for many years in our effort to prevent illness from effects of heat. His research and his practical recommendations have provided a program for prevention which makes sense for physicians and coaches. At least one high school football game in Ohio has been stopped and another temporarily delayed when the relative humidity reading climbed beyond a tolerable level. In both instances there was splendid cooperation among physicians, game officials and the coaching staffs.

Physician Advisors

Another significant recommendation adopted by the OSMA House of Delegates in 1962 urged schools to obtain the continuing services of a physician to advise coaches and trainers with regard to medical aspects of the athletic program—and to be available when medical emergencies arise in any sport.

The House of Delegates and the Council of OSMA have always supported the development of the sports medicine program. Also, the cooperation of the staff and Board of Control of the Ohio High School Athletic Association has been outstanding. They have exhibited complete trust and confidence in advice and direction from the medical profession.

For example, a physical examination form designed by the Committee has been used by OHSAA member schools for many years. This form is periodically reviewed by the Committee for possible revisions and updating.

An outstanding example of cooperation emerged from a tragedy in the early fall of 1969. Up to that time, it appeared that the Committee's continuing efforts in prevention of heat illness would be completely successful—at least for 1969. However, we were abruptly shocked by news that a high school player in Ohio had expired not long after running many laps on a hot and humid day. Recommendations of the Joint Committee about measures to prevent heat illness had not been followed. This unfortunate event emphasizes the need for repeatedly stressing preventive measures to combat heat illness and other medical aspects of sports.

The Joint Advisory Committee held an emergency meeting to investigate the fatality.

Proposals for Mandatory Regulations

During the meeting to analyze the cause of that player's death a list of proposals for mandatory regulations was formulated. It was approved by the OSMA Council and then adopted and implemented by the Board of Control of the OHSAA. Briefly, here are the highlights:

1. **Water** will be available on the field at all times during practice sessions and games.

2. A coach will be present throughout all practice sessions.

3. The first four days of fall football practice will be devoted solely to conditioning, and there will be no contact drills and no pads will be worn during this period.

4. The "weigh-in" and "weigh-out" chart prepared by the Joint Advisory Committee on Sports Medicine and distributed to all schools by the Ohio High School Athletic Association must be used before and after practice until the beginning of the regular season.

Last, but far from least, the Joint Advisory Committee is involved in the important fields of public information and physician placement at games, tournaments and special events.

A veteran writer who covers the high school sports scene for a metropolitan paper has been on one of our conference programs. So, if you are planning a conference on sports medicine—and have a slot for your friendly newspaper, radio, or TV personality—don't hesitate to consider him for a "piece of the action." It's good PR.

The OSMA Council recently approved a recommendation from the Joint Advisory Committee that OSMA go on record as strongly opposing the practice of "spearing" in interscholastic football. The request called for preparation of an appropriate news release for all daily and weekly newspapers, radio and TV outlets in Ohio.

News Media Cooperation

For the past several years—usually in late July—the Joint Advisory Committee has prepared a statewide news release concerning the risks from

high environmental heat. The article reminds scholastic athletes to begin conditioning well in advance of preseason practice in order to be acclimated to the extremely hot and humid weather which usually prevails in Ohio during mid-August and September. We've had excellent cooperation from the media. For example, the 1971 release was printed in at least 51 daily and weekly newspapers.

Placement of team physicians has not been a major function of the Committee to date—but we're hoping to become more active. This is a rather tricky business and requires again the close cooperation between the medical and the athletic association. When a game physician is needed, the OSMA may be notified. Our first step is to check with the school administration and/or coaching staff to see if a family physician of a player might fill the position. If there appears to be no possibility of securing a physician in this manner, we then consult our files from the 1970 survey of physicians interested in sports medicine and try to get one of them to take the assignment. The Joint Advisory Committee is devoted to the original mandate that everything possible must be done to insure that a physician is present for all athletic events in which injury or medical complication is a possibility.

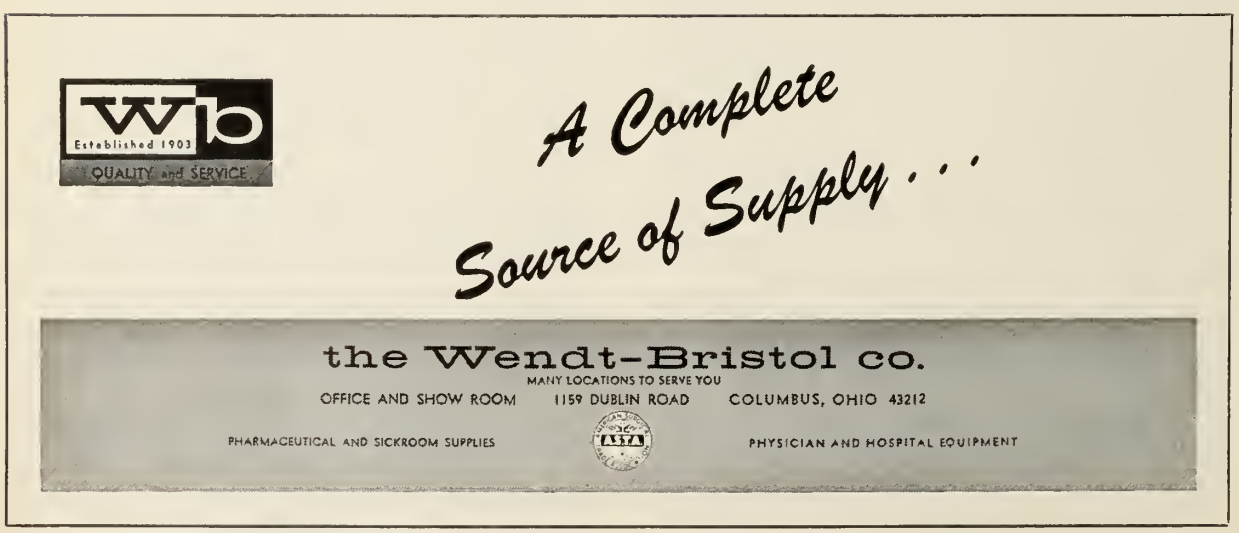
Other Activities

Other activities are numerous. Dr. Sol Maggied, chairman of the Committee, is currently involved in a study of fatalities among athletes caused by lightning. The Committee purchased a print of AMA's movie "The Team Physician" two years ago for loan to high schools, medical societies, and other groups. The Committee has been actively supporting a proposal for certification for all coaches of interscholastic athletes in Ohio. We favor inclusion of a course on medical aspects of sports in undergraduate physical education curricula. The Committee also is deeply involved in developing guidelines for weight loss for wrestlers and encouraging of women in competitive sports.

The Ohio High School Athletic Association discovered that many of the schools sending squads into Columbus for state tournaments do not include team physicians in the traveling parties. Members of our State Medical Association therefore have volunteered to attend state high school tournaments in basketball, baseball, track, wrestling and swimming and serve as game physicians.

This just about covers the major activities of the Joint Advisory Committee on Sports Medicine and the Scientific Section on Sports Medicine. As already mentioned, we've come a long way since the days of Galen. Of course, there's a long way to go. We need more sincerely dedicated physicians who are willing to serve our young athletes when needed, where needed, and as a labor of love if necessary.

We must redouble our efforts to educate our peers and the lay people involved in the athletic programs. It's a matter of the health and safety of thousands of young people engaged in worthwhile athletic programs.



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(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria ganorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhaeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for a least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonarrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic talerance studies in normal human volunteers, the fallowing were noted: a decrease in hemo

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jh cure rate:* 96% of 571 males, 95% of 294 females
)sages, sites of infection, and criteria for diagnosis and cure are defined below.)**

surance of a single-dose, physician-controlled treatment schedule

l allergic reactions occurred in patients with an alleged history of penicillin sensitivity en treated with Trobicin, although penicillin antibody studies were not performed

rive against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

ingle two-gram injection produces peak serum concentrations averaging about 0 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

e: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the nptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for norrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should e nstituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found persensitive to it.

a compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. ganarrhoeae* on Thayer-tin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-tment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even thaugh the w-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or ures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

in, hematocrit and creatinine clearance; elevation of alka-phosphatase, BUN and SGPT. In single and multiple-dose es in normal volunteers, a reduction in urine output was d. Extensive renal function studies demonstrated no con-nt changes indicative of renal toxicity.

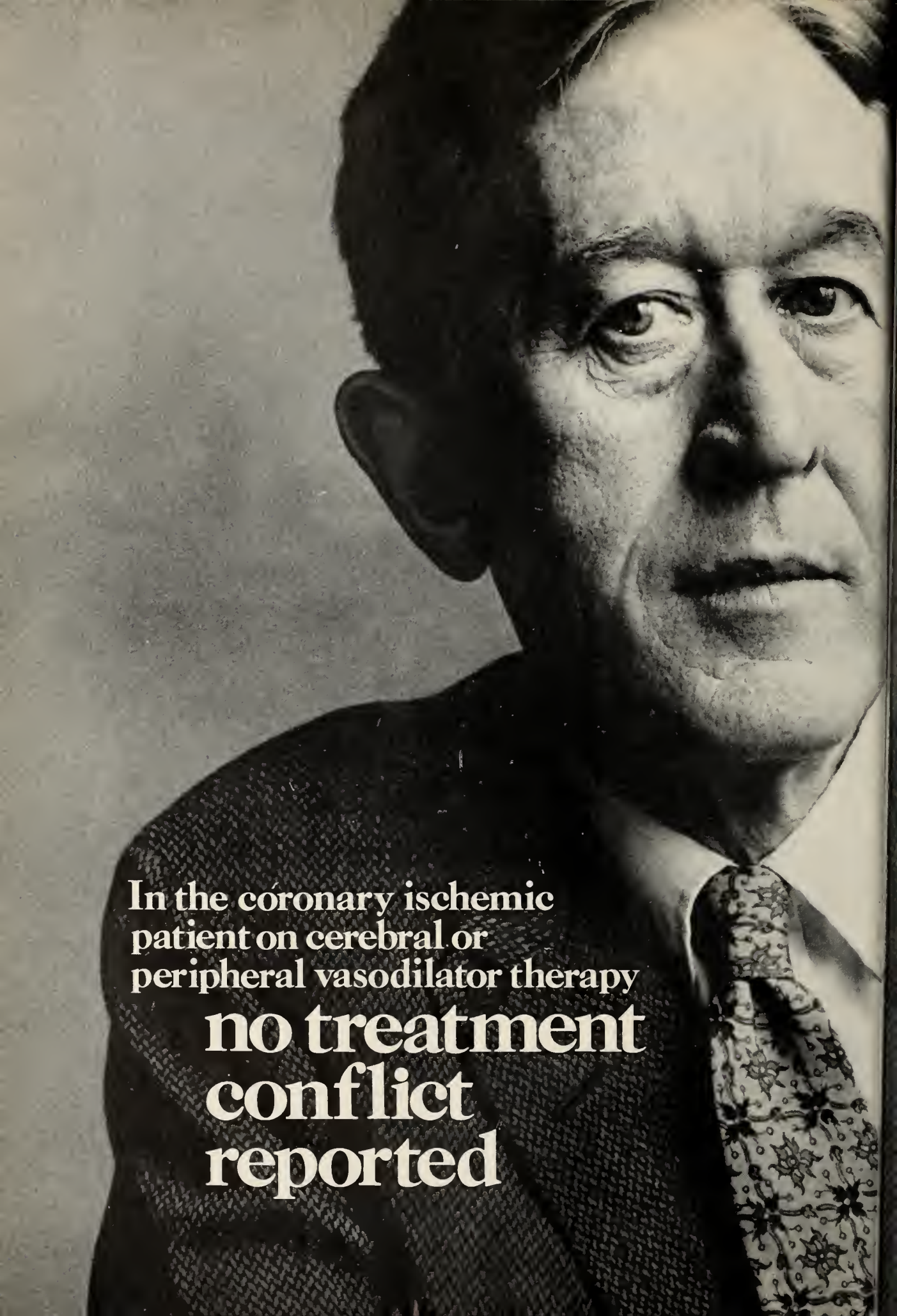
age and administration: Keep at 25°C and use within ours after reconstitution with diluent.
e—single 2 gram dose (5 ml) intramuscularly. Patients with orrheal proctitis and patients being re-treated after failure revious antibiotic therapy should receive 4 grams (10 ml). In graphic areas where antibiotic resistance is known to be pre-nt, initial treatment with 4 grams (10 ml) intramuscularly is erred.
ale—single 4 gram dose (10 ml) intramuscularly.

v supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. ganarrhaeae.*

Human pharmacology: Rapidly absorbed after intramuscular injection. A twa-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (4) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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New Eye Equipment Installed in Cincinnati

General Hospital, Cincinnati, recently installed a Zeiss photo-coagulator for the treatment of certain disorders of the retina. The new equipment was made possible by a $20,000 gift from the estate of the late Dr. Roy C. Harkrader, Cincinnati dentist, given to the University of Cincinnati Medical Center by the Ohio Lions Foundation.

The gift brings the total received by the University of Cincinnati from the Ohio Lions Eye Research Foundation to $185,000.

Health Guidelines for Visitors to Mexico

Guidelines for precautions to be taken when traveling to Mexico have been issued by the Ohio Department of Health for use by physicians in informing their patients who are planning to visit that nation.

Frequent inquiries are made to the Department regarding the occurrence of enteric diseases in Mexico and the precautions travelers should take to avoid these diseases. The following summary of current information on the status of typhoid, cholera, shigellosis, and other diarrheal diseases in Mexico, was provided by John H. Ackerman, M.D., chief of the ODH Bureau of Preventive Medicine.

There is no increased incidence of typhoid fever in Mexico. Typhoid fever in travelers has been extremely uncommon.

Cholera, while widespread in Asia, Africa, and the Middle East, has not been introduced into Mexico, and therefore, there is no need for concern about this disease. Cholera vaccine is not indicated for travelers.

Shigellosis is endemic in Mexico at the present time, although there are no widespread occurrences or epidemic situations.

Diarrheas due to other bacteria and unknown agents are a frequent source of illness and discomfort to travelers in Mexico. If the following precautions are observed, the traveler will, in most instances, avoid these diseases as well as the other more serious enteric disorders:

1. Avoid eating raw vegetables.
2. Fruit may be eaten safely if peeled by the consumer.
3. Drink only bottled water or other beverages or water **known** to be boiled. While water supplies are usually safe in major cities, it is better to take no chances.
4. Avoid eating establishments which do not appear to have good sanitary standards.
5. Do not take prophylactic medications such as enteric sulfa compounds, enteroviofform, or antibiotics. These substances alter the normal intestinal bacterial flora which may be protective against some of the diarrhea producing organisms.



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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur with relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, jitteriness. In contrast, CNS depression has been reported. In a few epileptics increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets. One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.), TEPANIL. One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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- Provides simple convenient dosage — usually just one tablet at bedtime

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Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nections caused by susceptible strains
pneumococci, streptococci, and
staphylococci, including penicillin-
resistant strains. Staphylococcal strains
resistant to Lincocin (lincomycin
hydrochloride, Upjohn) have been
recovered. Before initiating therapy,
culture and susceptibility studies should
be performed. Lincocin has proved
valuable in treating patients hyper-
sensitive to penicillin or cephalosporins,
since Lincocin does not share
antigenicity with these compounds.
However, hypersensitivity reactions
have been reported, some of these in
patients known to be sensitive to
penicillin.

Well tolerated at infusion site: Lincocin
intravenous infusions have not
produced local irritation or phlebitis,
when given as recommended. Lincocin
is usually well tolerated in patients who
are hypersensitive to other drugs.
Nevertheless, Lincocin should be used
cautiously in patients with asthma or
significant allergies.

In patients with impaired renal function,
the recommended dose of Lincocin
should be reduced to 25–30% of
the dose for patients with normal
kidney function. Its safety in
pregnant patients and in infants
less than one month of age has
not been established.

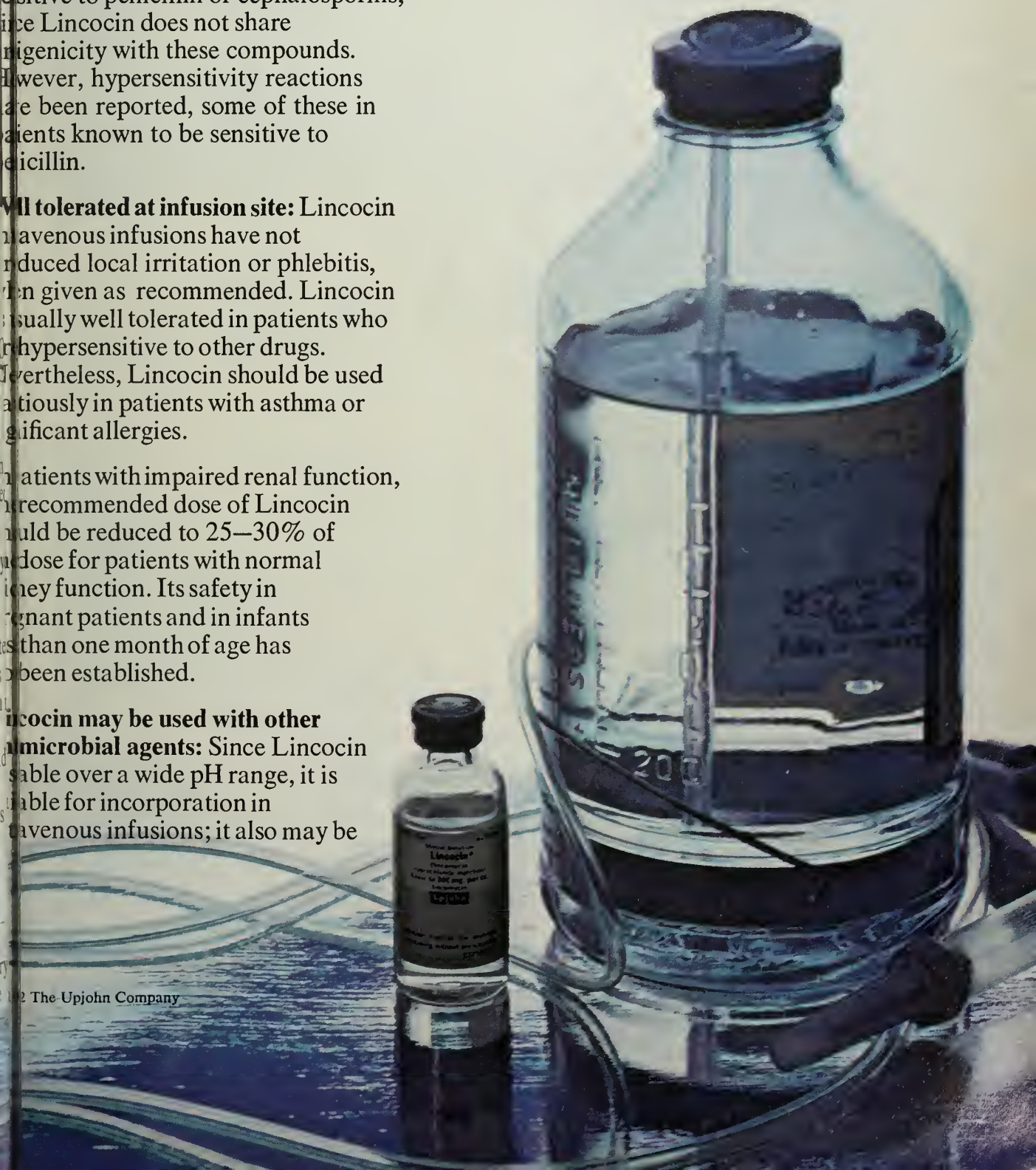
**Lincocin may be used with other
antimicrobial agents:** Since Lincocin
is stable over a wide pH range, it is
suitable for incorporation in
intravenous infusions; it also may be
administered concomitantly with other
antimicrobial agents when indicated.
However, Lincocin should not be used
with erythromycin, as *in vitro* antagonism
has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatm... *Skin and mucous membranes*—Skin ra... urticaria, vaginitis, and rare instances of ... foliative and vesiculobullous dermatitis ... been reported. *Liver*—Although no direc... lationship to liver dysfunction is establi... jaundice and abnormal liver function ... (particularly serum transaminase) have ... observed in a few instances. *Cardiovasc...* —Instances of hypotension following pa... teral administration have been repor... particularly after too rapid IV admini... tion. Rare instances of cardiopulmonary ... rest have been reported after too rapid ... administration. If 4.0 grams or more ad... istered IV, dilute in 500 ml of fluid ... administer no faster than 100 ml per h... *Special senses*—Tinnitus and vertigo ... been reported occasionally. *Local reac...* —Excellent local tolerance demonstrate... intramuscularly administered Linco... (lincomycin hydrochloride). Reports of ... following injection have been infrequ... Intravenous administration of Lincoci... 250 to 500 ml of 5% glucose in dist... water or normal saline has produced ... local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500* ... Capsules—bottles of 24 and 100. *St... Solution, 300 mg per ml*—2 and 10 ml ... and 2 ml syringe. *Syrup, 250 mg per 5* ... —60 ml and pint bottles.

For additional product information, co... the package insert or see your Up... representative.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN
Robert A. Gregg
Lima
Richard C. Weber
Lima

BUTLER
Albert A. Chambers
Middletown

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Donald F. Brittenum
John D. Clough
Michael A. Hanna
Irwin Kornbluth
Rashid N. Merchant
Peter Nintcheff
Jae Yoon Rhee
Paul T. Schnatz
Thomas W. Wykoff

HAMILTON (Cincinnati)
Charles H. Kuntz
Inayat U.K. Malik

LAKE
James M. Bearden
Mentor

LORAIN
Roger L. Baldoza
North Ridgeville

LUCAS
Dong Ki Cho
Toledo

MONTGOMERY (Dayton)
Siavosh Bozorgi
Barry I. Horwitz
Burton A. Kleinman
Thomas Wilson

SUMMIT (Akron except as noted)
Robert D. Burdette
James A. Lehman, Jr.
Cayetano S. Munoz
Sei Hyun Sunoo
Teddy Sworniowski
Barberton
Jon L. Weingart

Historical Note on Ohio Physician

In the November, 1971 issue of the *Wisconsin Medical Journal,* there appears a historical article entitled "Howard Culbertson, Harvey Hospital Surgeon."

The article notes: "However, unusual distinction came to Culbertson by winning the gold medal of the Ohio State Medical Society with his Prize Essay on 'The Use of Anesthetics in Obstetrics' in 1862."

[Editor's note: This action is further documented in the *Transactions of the Ohio State Medical Society, 1862.*]

The article further notes: "The hostilities of the Civil War made military service imperative for many physicians. From August 11 to September 13, 1862, Culbertson was Acting Assistant Surgeon, Ohio Volunteers, at a camp near Zanesville. November 7, 1863, he was appointed Surgeon, United States Volunteers. . . . With the activation of the Harvey Hospital, he was transferred to Madison (1863)."

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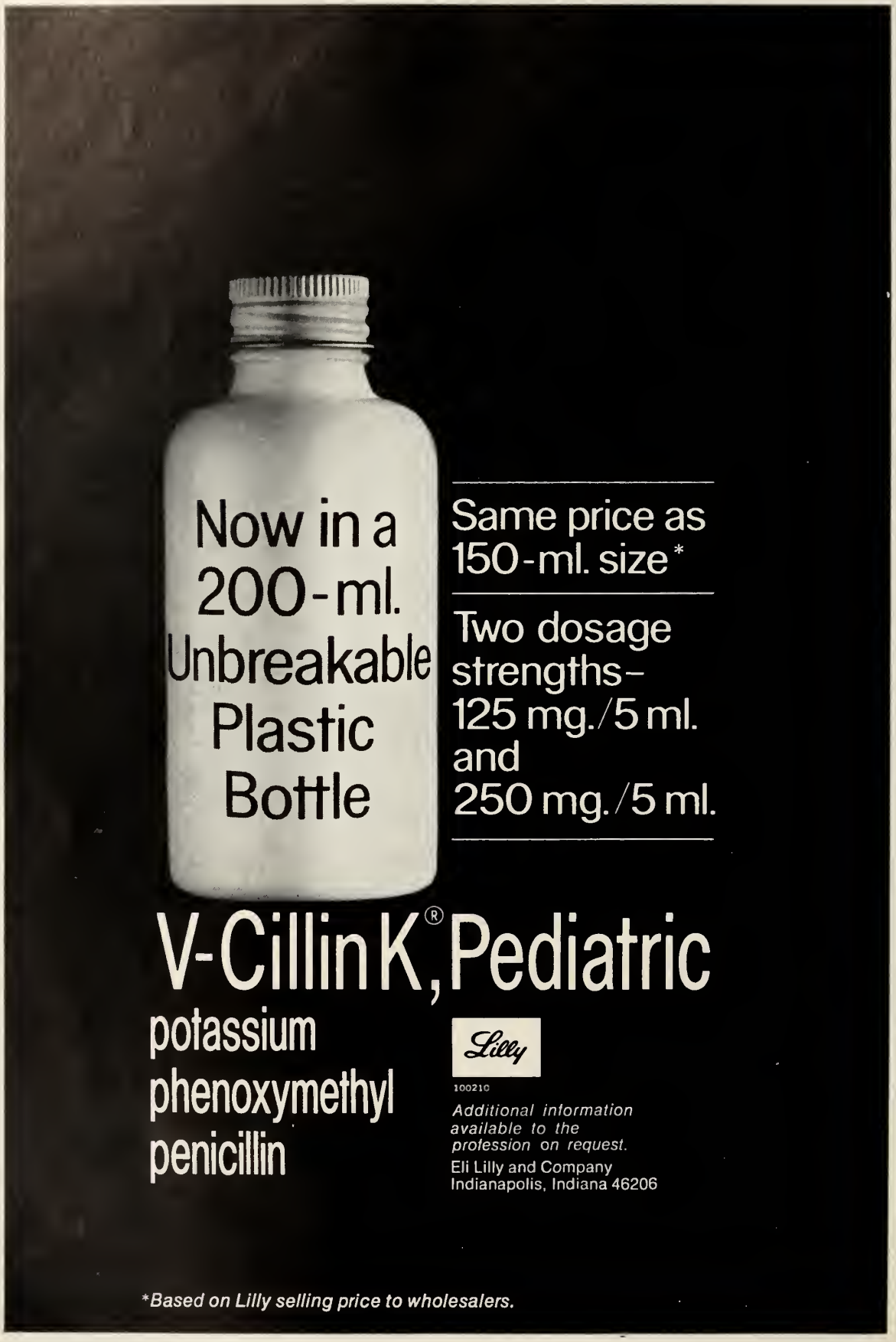
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Clinical & Scientific Features



Volume 68 January 1972 Number 1

Distal Bypass Grafts for Limb Salvage from Ischemia

William E. Evans, M.D., and Victor M. Bernhard, M.D.

ARTERIAL INSUFFICIENCY of the lower leg frequently results from arteriosclerotic occlusion of the superficial femoral artery. When required, reverse saphenous vein grafts from the femoral artery to the popliteal artery generally provide satisfactory revascularization. A rigid requirement for success is the presence of satisfactory outflow vessels below the level of the popliteal anastomosis. This requirement is met by the presence of patent distal popliteal and proximal tibial and peroneal arteries, allowing distribution of blood to the distal extremity. Patients are encountered in whom these distribution vessels are occluded, thus precluding bypass grafting to the popliteal artery. These patients generally have been considered to be unsuitable for revascularization and are offered local foot care, vasodilators, and occasionally sympathectomy. If ischemia is severe, these measures are of little benefit for the majority of patients, and loss of function and/or amputation commonly result.

When delayed arteriograms are obtained 20 to 40 seconds after following femoral artery injection in patients with popliteal and proximal tibial and peroneal artery occlusion, patent distal vessels are frequently visualized (Fig. 1). Recent experience has shown that many of these distal vessels are suitable for bypass graft reconstruction.[1-6] Our experience with 30 distal revascularization procedures, all followed at least eight months, have been reviewed and reported.

Submitted April 29, 1971.

The Authors

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Clinical Material

From July 1966 to June 1970, thirty distal tibial or peroneal artery revascularization procedures were carried out in 28 patients. Age

ranged from 23 to 75 years with an average of 59 years. Eighteen were 60 years of age or older. There were only five women in the group.

Indications for operation are shown in Table 1. Twenty-six operations were required for ischemia resulting from arteriosclerosis. Of these, four had rest pain, while 21 had ulceration and gangrene in addition to rest pain. The remaining patient required distal bypass graft because of obliteration of the proximal tibial and peroneal arteries associated with a popliteal aneurysm.

Four operations were required because of trauma. In two of these, tibial fractures destroyed the popliteal and proximal tibial-peroneal arteries. One resulted from femoral shaft fracture with thrombosis of these vessels, and the other was required because of a shotgun blast injury of the popliteal space.

Twenty-nine of 30 operations were done for severe ischemia. No patient has undergone tibial or peroneal bypass grafting for claudication alone. It must be stressed that these procedures were done for limb salvage, the majority of limbs clearly requiring amputation if revascularization was not accomplished.

Diabetes mellitus, verified by glucose tolerance testing and requiring therapy, was present in 13 patients. If patients with trauma are excluded, 13 of 24 (54 percent) had diabetes.

The posterior tibial artery was the site of distal anastomosis in 17 limbs, the anterior tibial in eight, the peroneal in four, and the dorsalis pedis in one. The common femoral artery was usually the site of proximal anastomosis. Autogenous reverse vein grafts were used in all procedures. In 24, saphenous veins were used. In eight, the saphenous vein was either unsuitable or had been previously removed. In these patients, cephalic veins from the arms were used. In the patients requiring operation because of trauma, vein grafts were harvested either from the contralateral extremity or from the arm.

Table 1. Indications of operation

Arteriosclerosis — 26		Trauma — 4	
Rest pain	4	Tibial fracture	2
Gangrene or ulcer	21	Femoral fracture	1
Popliteal aneurysm	1	Gunshot wound	1

Table 2. Results of grafts

No operative deaths
Eight months-56 months: 18/30 (66%) patent
Eighteen months-56 months: 12/24 (50%) patent

Patients have been followed from 8 months to over four years. Twenty-four procedures previously reported have now been followed for 18 months or more, providing an indication of long-term results.

Results

Results are summarized in Table 2. Eighteen of 30 (66 percent) of the grafts are functioning.

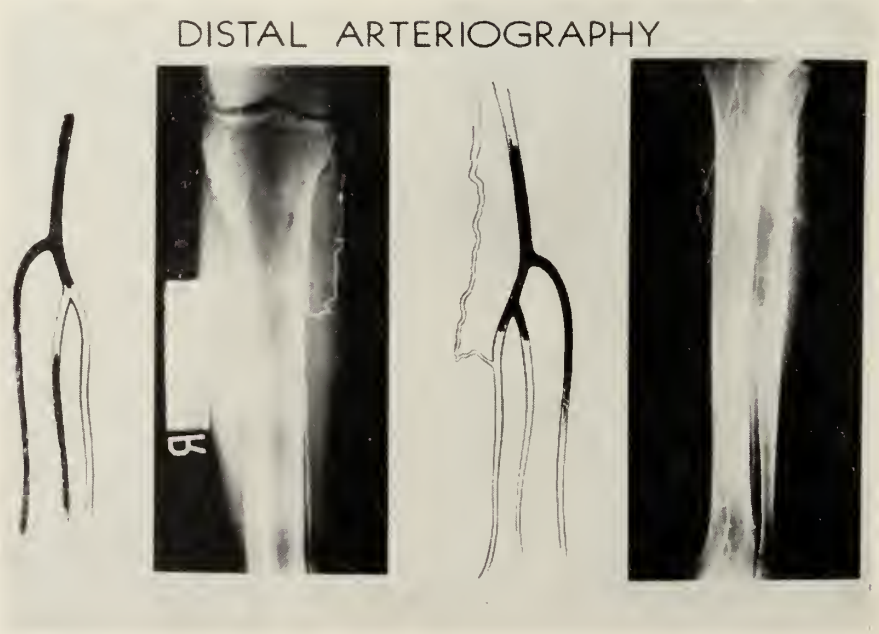


Fig. 1. Two examples of popliteal and proximal tibial-peroneal artery obstruction are shown. Collaterals fill posterior tibial and peroneal arteries.

All have been followed for eight months or longer. With functioning grafts, viability has been maintained and function has returned. Twelve grafts failed (34 percent). In three grafts, failure occurred initially. Satisfactory blood flow was never achieved at the time of surgery. All three required amputation. Three additional grafts originally functioning failed in less than four months. Two of these required amputation. The other developed severe symptoms of ischemia. Six late failures occurred 6 months to three years after surgery. Each developed significant symptoms, but viability has been maintained. In all, five amputations were required (16 percent). This includes three patients who could not be revascularized and two whose grafts failed in the early postoperative period. When graft failure has occurred at six months or more after their insertion, symptoms have routinely recurred but viability has been maintained.

The cause of graft failure was examined. In seven grafts, the extent of the disease precluded revascularization, or rapid progression led to early graft occlusion. In one, a tourniquet was applied during a plastic surgical procedure to the foot, leading to graft occlusion. The patient underwent a second graft which was successful. In four patients, grafts were inserted above levels of significant occlusive disease. An example is shown in Figure 2. It is now felt that bypass grafts should be carried to a point distal to all evidence of occlusive disease. If this policy had been followed, patency might have been achieved in these patients.

Diabetic patients fared as well as nondiabetic. If the four extremities operated for trauma are excluded, 6 of 12 limbs in the nondiabetic patients remained patent, while 8 of 14 are patent in the diabetic group.

Twenty-two patients requiring 24 bypass procedures have been previously reported. All of these patients have now been followed 18 months or longer. Our initial report showed 17 of 24 grafts patent (70 percent) from 4 to 40 months. Since that report, three patients have been lost to follow-up. Of the 14 patients followed longer than 18 months, 12 are still patent from 18 to 56 months after surgery (86 percent). Of the original 24 grafts, 12 (50 percent) are now patent.

Of the two additional graft failures occurring in the last 16 months, one occurred in a patient with Marfan's syndrome, who at age 37 has required multiple revascularization procedures, and the other occurred in a 50-year-old diabetic patient with severe obliterative disease, in whom the graft was originally extended to the dorsalis pedis artery. This graft survived for nearly 18 months during which time ulceration of the foot healed, a gangrenous toe was removed, the incisions for which ultimately healed, and salvage was obtained. Following occlusion of this graft, claudication has returned; however, this extremity remains viable.



FIG. 2. Graft placed high in posterior tibial artery failed. Probable cause of failure was presence of high-grade stenosis at midcalf level.

Comment

Evans,[1] Tyson,[2] Garrett,[5] and Noon[6] have clearly shown that distal vessels are frequently patent when popliteal and proximal tibial-peroneal obstruction occurs and that distal revascularization to the tibial and peroneal arteries results in limb salvage of a significant number of these ischemic extremities. In our experience, as well as others, 60 to 70 percent early patency with limb salvage can be expected. Late results show patency and salvage of at least half of the limbs operated. When one considers that the vast majority of these patients are amputation candidates, this salvage rate is encouraging. In addition, no operative deaths occurred in this small group. It is to be expected from mortality data on femoral popliteal bypass grafting procedures as well as the reported tibial grafting operations that the morbidity and mortality should be no greater than

that of a major amputation, which will most certainly be required in the majority of these patients if revascularization cannot be accomplished.[1-6] These factors would indicate that attempted revascularization should be given serious consideration.

Technical procedures of these bypass grafts have been reported in detail elsewhere.

Summary

Thirty distal revascularization procedures have been reviewed and reported. The technical feasibility of extension of bypass grafts to the distal tibial and peroneal vessels is now well established. That revascularization with resultant limb salvage can be accomplished in a significant number of these patients prompts arteriographic evaluation of these patients. When patent vessels are demonstrated distally, the extension of the bypass graft should be considered.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 42-year-old man presents with a neck mass located below his mandible (Fig. 1). The mass enlarges and becomes painful at mealtimes, then it gradually decreases in size over the next several hours. Bimanual palpation reveals a tender 4 x 4 cm freely movable mass beneath his mandible. Pressure on the mass results in a small amount of mucopurulent material to be extruded from the opening of Wharton's duct. (This is located in the midline floor of the mouth just adjacent to the frenulum of the tongue.)

What is your diagnosis, further evaluation, and treatment?



Fig. 1. Arrow points to tender, firm mass located beneath mandible.

(See p. 46 of this issue for further information and discussion.)

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Submitted March 31, 1971.

Anatomic Variations Demonstrated by Selective Angiography

Report of Two Cases

KAPPAGANTULA P. SARATHI, M.D.; SUK SOON LEE, M.D.; FRANK I. SHUMAN, M.D.; AND EMIL GUTMAN, M.D.

THE PURPOSE of this paper is to present two important anatomic variations demonstrated by selective angiography: (1) origin of the left hepatic artery from the left gastric, and (2) the gastroduodenal artery arising from the superior mesenteric. A knowledge of these is important in surgical procedures.[1]

Developmental Anatomy

The embryonic liver is supplied by three vessels, the right, middle, and left hepatic arteries. Usually the left and right become atrophic and persistence of either or all three arteries leads to the following variations.[1]

1. In about 70 percent of cases, the embryologic middle hepatic artery supplies the liver. After its origin from the celiac axis, it gives off the gastroduodenal, the posterior superior pancreaticduodenal, the pyloric, and cystic arteries, and it finally divides into right and left branches to supply the parenchyma of the liver. In 6 percent of these, it divides before giving origin to the gastroduodenal.

2. In a relatively large number of cases, 19 to 25 percent in different reports,[2] the left hepatic arises from the left gastric artery.

3. All three hepatic arteries persist in about 3 percent of cases.

4. In 7 to 9 percent, the middle may involute, and the blood supply of the liver is shared by the right and left hepatic arteries.

Submitted April 5, 1971.

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In the case reported (No. 2), the left hepatic artery has been found to arise from the left gastric artery. Because of the frequency in which this variation has occurred, it was also called the "gastrohepatic artery" by Haller.[4] In one-half the instances, it completely replaces the left hepatic, and in the rest, it exists as an accessory branch. In these instances, the artery may run in front or behind the portal vein.

Severance or ligation of this artery, when it completely replaces the left hepatic artery, leads to fatal hepatic necrosis,[3] immediate death, or



FIG. 1 (Case 1). Selective celiac showing stretching of vessels in lower poles of liver and spleen.



FIG. 2 (Case 1). Selective superior mesenteric arteriogram, showing gastroduodenal arising as first branch.



FIG. 3 (Case 2). Right side arrows show the left gastric and hepatic arteries. The liver, a tumor blush (three left arrows).



FIG. 4 (Case 2). Single arrow shows the left hepatic artery arising from the left gastric. Double arrow shows tortuosity of the hepatic branches.

renal insufficiency secondary to hepatic necrosis—the so-called "hepatorenal" syndrome.[4]

The gastroduodenal artery normally (75 percent) arises from the common hepatic trunk first on the left side of the common bile duct, crosses it, runs dorsally to the first part of the duodenum, and divides into the right gastroepiploic and the superior pancreaticoduodenal arteries. The variations of the artery include its origin[3] from: (1) the left hepatic in 11 percent; (2) the right hepatic in 7 percent; (3) the middle hepatic in 1 percent; (4) a replaced hepatic trunk in 3.5 percent; and (5) the celiac or superior mesenteric artery in 2.5 percent of cases.

Case Reports

Case 1. This 37-year-old white man had a complaint of pain in the left flank of four weeks' duration prior to his admission to the Veterans Administration Hospital on November 6, 1970. The pain was localized and associated with a temperature of 100 F (37.8 C). He had similar episodes in April, July, and October 1968. The clinical impressions on those admissions included irritable colon, cirrhosis of the liver, and psychosomatic reaction. He also developed marked weakness and had a weight loss of 24 lb (10.9 kg) in four weeks. Except for tenderness in the left hypochondrium, physical examination was negative.

Laboratory data, including hemoglobin, urinalysis, urea, electrolytes, alkaline phosphatase, blood sugar, liver function tests, amylase, and serum transaminases were within normal limits. However, at the time of admission, amylase was 276 units and the white blood cell count (WBC) was 18,100 per cu mm, with a differential of polymorphonuclear leukocytes 88 percent, lymphocytes 11 percent, and eosinophils 1 percent. An intravenous pyelogram done on October 25 showed narrowing and kinking of the left ureter. An upper gastrointestinal examination on November 25 showed slight anterior displacement of the stomach in the lateral view suggesting a retroperitoneal mass. Selective left renal, celiac, and superior mesenteric angiography was performed. The celiac and superior mesenteric studies showed stretching of the arteries of the lower pole of the liver and spleen without evidence of encasement, irregularities, or a tumor blush (Fig. 1). The anomalous origin of the gastroduodenal from the superior mesenteric artery was demonstrated (Fig. 2).

The patient had an exploratory operation on December 29, 1970. A pseudocyst with a diameter of 7 cm was found in the tail of the pancreas. Splenectomy and removal of the cyst was carried out. Biopsy of a lymph node removed at the same time revealed nondiagnostic lymphoid hyperplasia.

Case 2. This 56-year-old white man was admitted on September 16, 1970 with the complaint of pain in the abdomen and chest associated with vomiting, shortness of breath, weakness, and flushing.

Past history revealed the patient had a resection of the colon in March 1970 and pathologic examination at that time showed malignant carcinoid of the ileum. Physical examination was unremarkable.

Laboratory data, including hemogram, fasting blood sugar, blood urea nitrogen, Venereal Disease Research Laboratories, prothrombin time, urinalysis, cholesterol, serum transaminases, and alkaline phospratase tests, were within normal limits. Small amounts of 5-hydroxyindoleacetic acid were reported in the urine. A liver scan was negative and liver biopsy showed interspersed malignant carcinoid from the ileum.

A selective celiac arteriogram, to estimate the extent of metastases, demonstrated questionable tumor blush and stretching of the vessels in the left lobe of the liver (Fig. 3). The changes were not striking because of the smaller amount of contrast material used. The left hepatic artery, arising from the left gastric instead of the common hepatic, supplied the left lobe of the liver (Fig. 4).

Conclusion

In case 1, knowledge of the anomalous origin of the gastroduodenal from the superior mesenteric artery around the pancreatic head facilitated the surgical removal of the pancreatic pseudocyst.

In case 2, knowledge of left hepatic artery arising from the left gastric helped in localizing the disease in the left lobe of the liver.

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The Reliability of Blood Tests Drawn from Intravenous Lines

Edward F. Jackson, Jr., M.D.

THIS STUDY was undertaken to test the reliability of blood tests drawn from indwelling intravenous lines as compared with those drawn by venipuncture. The advantages of drawing blood from indwelling catheters are obvious to the patient who is subjected to serial or repeated blood studies (eg, "cardiac" enzymes, blood sugars, or Lee-White tests) and to the technician faced with obtaining the samples. The medical personnel asked to start intravenous (IV) therapy on veins well hidden behind hematomas might also favor the technique described in this study. However, the advantages of the technique would not be worthwhile if the laboratory studies were not reliable when obtained in this manner; hence this study.

Methods

Patients admitted to this study met three requirements:

(1) They each had a central venous catheter (CVC) in either antecubital fossa, extending in at least 18 inches.* In most cases, a catheter so placed in a basilic vein will have its tip in the subclavian or jugular vein or the superior vena cava; or, if in a cephalic vein, the tip will be on the anterior chest over the pectoralis muscles.

(2) They each had a four-way stopcock in the IV train, and blood could be freely aspirated through the catheter (Fig. 1).

(3) Except for one patient seen early in the study, they each had upper limb veins from which blood could be obtained. When we encountered a patient on whom venipuncture could not be done, we assumed the CVC sample to be reliable and did not subject him to femoral venipuncture.

When neither the CVC nor the venipuncture would yield blood, the author performed femoral venipuncture.

Most of our cases were patients admitted to the medical or surgical service of the Mount Carmel Hospital, in whom the physicians attending felt central venous pressure monitoring might be useful; a few had central venous catheters placed because prolonged IV therapy was expected and an assured IV route was desired. During the period of study, January to May 1970, whenever blood studies were ordered on patients in this study, the author and one technician from our laboratory went to the bedside to draw samples in duplicate. The author's method was to uncap the exit port of the stopcock and to withdraw 10 milliliters of blood, which was discarded; the syringe was kept clean. Enough blood was then aspirated with another syringe to determine sodium, potassium, chloride, carbon dioxide, urea nitrogen, glucose, hemoglobin, hematocrit, leukocyte count, platelet count, serum osmolality, Lee-White time, prothrombin time, and any study the physician had ordered

*See appendix for equipment description.

The author was awarded third prize for this paper in the competition held by the Columbus Society of Internists on June 15, 1971.

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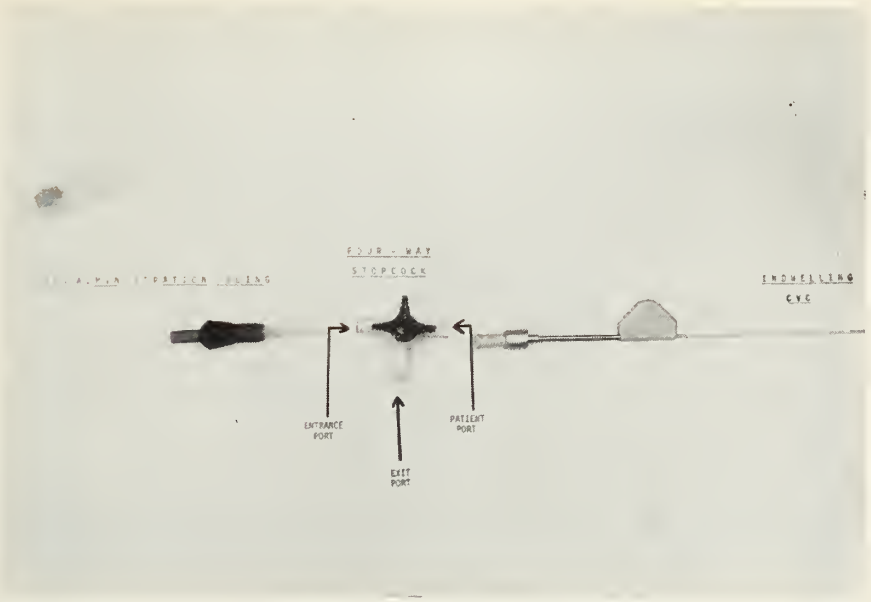


FIG. 1. Three major components of our CVC setup. CVC shown, with placement needle and protective cap, is used for all percutaneous CVC placements and some cut-down placements. We occasionally use the larger caliber Intramedic PE 205 for cut-downs.

which might not be on this list (Table 1). Next, the stopcock was adjusted so the IV solution flowed through the patient port to clear the CVC. The stopcock was adjusted so that the IV solution flowed out the exit port to clear the blood, and the still clean syringe was used to aspirate any fluid left in the exit port. The port was recapped, and the contents of the IV solution were noted (Fig. 2). The IV site was inspected for local and ascending erythema and tenderness. The technician then took a like volume of blood by venipuncture of the opposite arm. The samples were run through our laboratory in the usual manner. The technicians always knew which sample was which, but we did not expect error from that quarter, since all the studies are automated except the platelet count and Lee-White time.

Discussion

The studies listed were obtained on 18 patients and totaled about 40 paired samples for each laboratory value. The statistical significance of the difference in the CVC samples versus the venipuncture samples was evaluated by the t test. Please see the table; when t is between −1.69 and +1.69, the difference between CVC and veni-

TABLE 1. Statistical Tabulation and Analysis of Substances Tested

	CVC Mean	Standard Deviation	Venous Mean	Standard Deviation	Patient Samples	Mean Difference CVC Vein	Standard Deviation	t
Sodium	139	5	140	5	38	0.3684	1.28	1.771
Potassium	4.3	0.7	4.4	0.8	38	0.113	0.1818	3.836
Chloride	100	6	101	6	38	0.63	1.89	2.054
Carbon dioxide	27.4	4.7	27	5	38	0.23	2.5	0.57
Urea nitrogen	36	40	36	39	37	−0.35	0.9	−2.25
Glucose	176	81	180	82	36	4.0	11.07	2.1
Hemoglobin	13.1	3.1	13.4	3.0	38	0.79	2.5	1.8
Hematocrit	39.4	8.7	40.2	8.4	38	0.71	0.92	4.78
Leukocytes	13,044	8,904	12,917	9,340	38	−155	791	−1.21
Lee-White	27.4	25.4	27.2	26.2	25	−0.22	6.69	−0.164
Prothrombin time	79	18	80	18	35	1.5	5.3	1.6
Osmolality	302	22	302	21	36	0.25	3.2	0.462
Platelets	240,027	159,688	242,081	144,215	37	4.39	33.5	0.79

In this chart those values whose differences are not statistically significant have a t between −1.69 and +1.69. See text discussion of statistically significant differences.

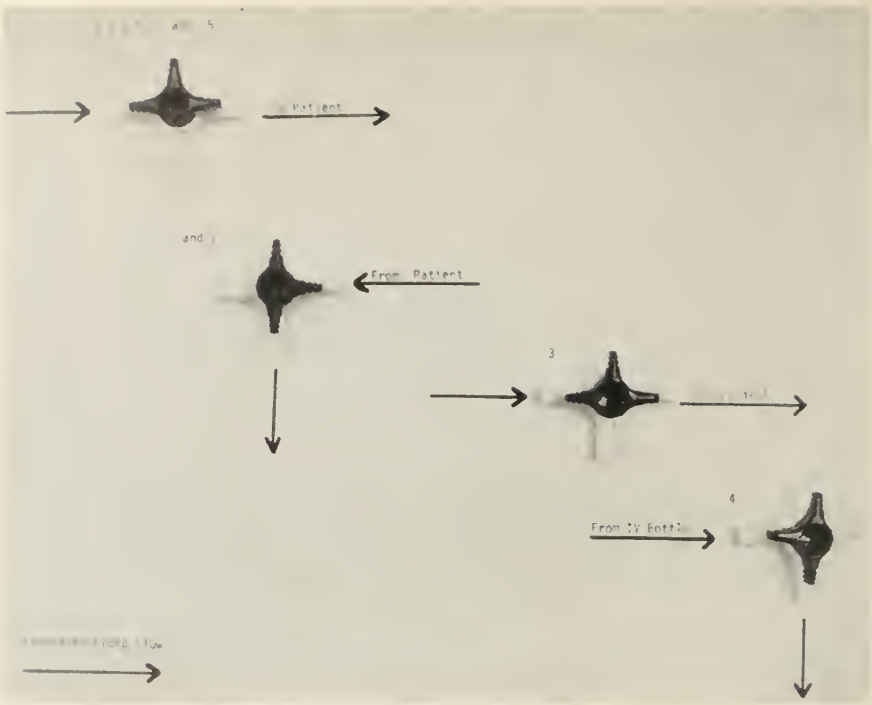


FIG 2. Four-way stopcock and steps used in drawing blood samples. Start: fluids running into patient (1) exit port uncapped and 10 milliliters of blood withdrawn and discarded; syringe is kept clean. (2) With another syringe, samples for study are taken. (3) CVC immediately cleared with IV fluids. (4) Exit port flushed with IV fluids and aspirated to clear blood. (5) Exit port cleaned and recapped.

puncture samples is not statistically significant ($p=.05$). In the cases of carbon dioxide, leukocytes, Lee-White, prothrombin time, osmolality, and platelets, there were no statistically significant differences. In the case of sodium, potassium, chloride, urea nitrogen, glucose, hemoglobin, and hematocrit, the differences were statistically significant. In these cases the raw data, means, and standard deviations were reviewed and while there appears to be a trend in the various differences (usually venipuncture greater than CVC), there are no clinically significant differences in these laboratory values.

The idea that blood studies might be drawn from indwelling intravenous lines with the same reliability as those drawn directly from venipuncture is neither unreasonable nor original, however, there are possible sources of error. The effects of the tubing or substances absorbed thereon; that of the substances in the IV fluids; and the method of sampling are not known. We think that the data gathered herein support the common sense notion that blood drawn from CVC is not different, for practical purposes, from that drawn from the vein, at least for the laboratory values studied and with the technique and equipment described. In fact, in our hospital now, all patients with such equipment have their studies (except blood cultures) drawn in the described manner; those in the intensive care unit by the nurses there, and those in the general hospital by specially trained laboratory technicians or by the house officer.

The IV fluids encountered in the study included dextrose 5 percent in distilled water, physiological saline, Ringer's lactate, 0.45 percent saline, 0.2 percent saline, and numerous additives including vitamins, antibiotics, heparin, and potassium chloride. We could detect no effect of the solution or additives on the differences found between CVC and venipuncture bloods.

This study was not directly concerned with the dangers arising from indwelling catheters, but we did note a moderate number of patients with local and ascending phlebitis. We did not encounter systemic infection, which we were able to blame on the catheters. For the last three years, we have dressed all IV sites daily with antibiotic ointment, and we do not place tape directly over the venipuncture site. We have no controlled series, and therefore no proof that such dressings are useful (in fact, the only case of catheter sepsis encountered by this author in three years occurred in a patient whose IV site was dressed daily and in whom there was no phlebitis): but we insist on antibiotic redressing daily if for no reason but good technique. We do not want the ease and reliability

of the CVC technique to obscure the fact that indwelling IV catheters are not without danger.

Summary

About 40 paired samples of blood were taken from 18 patients; there was no significant difference to be found between CVC blood and venipuncture blood. The method of drawing blood from such equipment has become standard practice in our hospital. It is also standard practice to redress the IV site with antibiotic ointment daily.

Appendix

When the CVC was placed percutaneously the Desseret #3132 or #3182 Intracath was used. CVCs placed by venous cut-down were often the same catheter with the placement needle removed. A few house officers used the Intramedic PE 205 catheter. The Baxter R-62 or R-62A four-way stopcock was used in all cases.

Acknowledgement: My thanks to Drs. H. B. Davidson and M. A. Anthony for critical review, to Miss Mary Shaw for technical assistance, and to Dr. R. Nuenke for statistical analysis.

PUMP FAILURE. —The potential effectiveness of direct coronary-artery revascularization in the treatment of shock complicating acute myocardial infarction depends upon the existence of functionally compromised ischemic myocardium that, when revascularized, will regain contractility and markedly improve left ventricular function. Laboratory studies have shown a variable extent of ischemic, functionally compromised, viable myocardium in the peri-infarction zone after acute occlusion of a major coronary-artery branch. Myocardial ischemia without actual necrosis has been reported to cause an appreciable decrease in myocardial contractility, and, if extensively involving the left ventricle, results in left ventricular power failure. Continued ischemia of this zone may lead to necrosis and extension of the infarct, often with a fatal outcome. Braunwald, et al have suggested that the survival of the patient with coronary occlusion will be determined by the balance between myocardial oxygen supply and demand. There have been some striking successes of intra-aortic balloon-pump assistance in several cases, particularly when circulatory assistance has been instituted early in the course of cardiogenic shock. The lack of success of mechanical circulatory-assistance devices to improve long-term survival in pump failure associated with acute mycardial infarction in some cases may be related to the fact that these devices only *temporarily* reduce myocardial oxygen demand and may have to be terminated before intercoronary collateral circulation can sufficiently develop for appreciable improvement in myocardial oxygen supply of the involved segment of myocardium.

The combination of mechanical circulatory assistance and direct coronary arterial revascularization may improve the survival of these patients by both temporarily reducing myocardial oxygen demand and increasing myocardial oxygen supply. In the patient described, it is clear that the adjunct of mechanical circulatory assistance was essential. Prompt institution of intra-aortic balloon-pump assistance prevented continuing deterioration and allowed safe diagnostic study and induction of anesthesia. The effect of coronary revascularization on left ventricular function was immediately apparent in terms of the capability of the previously failing heart to maintain circulation without mechanical circulatory assistance. Thus, it is apparent from this case that left ventricular function can be greatly improved and that progressive left ventricular power failure associated with acute myocardial infarction can be reversed by acute coronary revascularization. It is hoped that the therapeutic approach illustrated in this case report of early institution of intra-aortic balloon-pump circulatory assistance, prompt diagnostic study, and emergency direct coronary-artery surgery will increase survival of patients with acute myocardial infarction and cardiogenic shock. —Eldred D. Mundth, M.D., et al, Boston: *The New England Journal of Medicine*, 283:1382-1383, Dec. 17, 1970.

Pacemaker Click
A Clinical Diagnosis

Naiyer Habib, M.D., and Ralph D. Lach, M.D.

VARIOUS NEW physical findings and the modification of normally present ones have been recognized as a result of insertion of cardiac pacemakers.[1,2] For example, the signs of atrioventricular dissociation: variable S_1, cervical venous cannon waves, inconstant gallop, and reverse splitting of S_2, are usually present when there is normal atrial mechanical activity with a right ventricular pacemaker. The same findings exist with a left ventricular (epicardial) pacemaker, although the splitting of the second sound in that instance is not reversed but of an exaggerated physiologic type, as is usually seen in complete right bundle branch block.

When there is variation in these findings on clinical evaluation, one must suspect a variation in pacemaker function. The following report describes a phenomenon which is being recognized with increasing frequency with comments on its probable etiology. This phenomenon is the pacemaker click or sound. Its recognition is essential to the avoidance of confusion at the time of physical examination of patients with implanted pacemakers.

Case Report

A 72-year-old white woman had placement of a right ventricular endocardial asynchronous pacemaker for the treatment of complete heart block. Routine physical examination after a year showed a regular pulse rate of 72 beats per minute. Also noted was an impulse in the left fifth intercostal space in the midclavicular line. This had not been present previously. On auscultation, the anticipated variation in the intensity of the first heart sound was not present. Instead, a loud, high-pitched sound was audible in the left fourth and fifth intercostal spaces, just medial to the cardiac apex. This sound coincided with the abrupt impulse palpated in the same location on the anterior chest wall. The patient was not aware of any unusual precordial activity when specifically asked about this impulse. The remainder of the findings were as anticipated with reversed splitting of S_2, cervical venous cannon waves, and intermittent atrial gallop sound.

Standard 12-lead electrocardiogram showed a totally paced rhythm with atrioventricular dissociation and no evidence of atrioventricular conduction. Chest roentgenogram showed no appreciable change in the position of the pacemaker since its placement in the right ventricle. Chest fluoroscopy showed no evidence of diaphragmatic stimulation synchronous with the pacemaker.

Phonocardiography was performed with a Cambridge multi-channel recorder. Recordings were made of the phonocardiogram, electrocardiogram, and of a volume displacement apex cardiogram pickup placed over the suspect area of the left chest.

Analysis of the electrocardiogram revealed total control of the ventricles by the pacemaker.

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Following the pacer spike by an approximate interval of 10 to 15 milliseconds, the phonocardiogram tracing showed a brisk, high intensity sound. This was followed immediately in the apex cardiographic tracing by an abrupt positive wave which reached a peak of approximately 120 milliseconds after the onset of the pacemaker spike of the electrocardiogram. Also of note in the phonocardiographic tracing is the presence of atrial sounds following P waves unrelated to the QRS and the anticipated variability of the first heart sound whose intensity seemed to vary inversely with the duration of the P-R interval (Fig. 1). This variable intensity of S_1 was recordable but not distinguishable from the loud, high pitched pacemaker click by auscultation.

Discussion

A presystolic sound related to a right ventricular endocardial pacemaker has previously been noted.[1,2] Various mechanisms have been proposed. The most likely is that of chest wall stimulation,[2] although identification of chest wall muscle motion has not always been achieved. This pacemaker sound may be of high or low intensity and may be constant or intermittent, related to the phase of respiration or patient position.[2,3]

With the increasing frequency of patients in the general population who have indwelling cardiac pacemakers, it becomes important to recognize this possible variation in cardiac auscultation since it may mislead the examiner in regard to the status of the patient's pacemaker. When the pacemaker sound is of low intensity, it may mimic a closely apposed atrial sound and, when it is of high intensity, it may be of sufficient amplitude to mask the auscultation of the first heart sound, as was the case in the patient presented here.

In conclusion, when the clinician is confronted by a patient with a previously implanted cardiac pacemaker, in whom there is an apparently constant S_1 by auscultation, a tabular analysis (as in Table 1) can be made to identify the nature of this unusual physical finding.

It should be noted that there has been no case reported of pacemaker clicks associated with left ventricular (epicardial) pacemakers. A presystolic diaphragmatic sound, due to stimulation of phrenic nerve, has been noted.[1,4] This may also occur via the right phrenic nerve with atrial pacemakers. Pacemaker stimulation of the chest wall is, of course, more likely to occur if the pacemaker has traversed the right ventricular myocardium and lies either in the pericardial sac or mediastinum just beneath the anterior chest wall. However, the majority of patients with pacemaker stimulation of

Table 1. Unusual Physical Findings in Patient with Previously Implanted Cardiac Pacemaker.

	Pacemaker Failure	Paced Rhythm	Pacemaker Sound
Change in heart rate	+	−	−
Varying "S_1"	±	−	−
Cannon waves	±	+	+
Reversed splitting of S_2 (RV pacer only)	−	+	+
Palpable abrupt chest wall movement	±	−	+
Paced rhythm on EKG	−	+	+



Fig. 1. Abbreviations. ECG = Electrocardiogram, PCG = Phonocardiogram, ACG = Apex cardiogram, PS = Pacemaker spike, PC = Pacemaker click, and AS = Atrial sound. ECG shows paced ventricular beats and dissociated P and QRS complexes. Pacemaker spike (PS) precedes pacemaker click (PC). Pacemaker click (PC) coincides with onset of apex cardiogram (ACG). S_1 is obviously variable in intensity. Atrial sounds (AS) are seen following the last two P waves.

the chest wall have not had myocardial perforation. There seems to be a greater likelihood for such chest wall stimulation if the pacemaker is seated in an anterior portion of the right ventricle and if the chest wall tends to be narrow in its anteroposterior diameter.

As one proceeds through the analysis in Table 1, most of the distinctions may be self-evident but several are subject to variation. In pacemaker failure, the heart rate will usually change from that seen at the time of placement of the pacemaker. Of course, in the ventricular-suppressed and ventricular-triggered demand pacemakers, there may be no pacemaker function if the endogenous ventricular rate is greater than that preset in the pacemaker. Precise maintenance of the previous ventricular paced rate is in favor of normal functioning of the pacemaker. Variation in the first heart sound is almost universal in normally functioning cardiac pacemakers except in those instances where the supraventricular mechanism is that of sino-atrial arrest or atrial fibrillation. Since atrial synchronous pacemakers are no longer used to any great extent today and since the newer "sequential" atrioventricular pacemakers[5] are still in their experimental phase, a constant relationship of P to QRS is almost never observed, precluding the occurrence of a constant first heart sound. Cannon waves are almost always seen in patients with complete heart block, whether they are paced or not, provided the atrial mechanical activity is intact.

Reversed splitting of S_2 is the rule in patients with a right ventricular endocardial pacemaker, whether there is associated stimulation of the chest wall by the pacemaker or not. In patients who have developed pacemaker failure, reversed splitting of S_2 may be seen when the idioventricular pacemaker originates in the right ventricle, or when a conducted rhythm is associated with complete left bundle branch block or other conditions impairing electrical or mechanical aspects of left ventricular ejection. Palpable movement of the anterior chest wall, when present, may be associated with stimulation of the diaphragm, or if discrete and well localized, it probably signifies stimulation of the anterior chest wall. When seen along with other signs of pacemaker failure, it should, in all likelihood, be construed as evidence for perforation of the pacemaker through the anterior ventricular wall. As previously stated, stimulation of the phrenic nerves will give a unilateral hiccough which can be detected fluoroscopically and which may occur through the intact myocardium, either with a right ventricular electrode or with accidental displacement of a permanent ventricular pacemaker into the right atrium. With the advent of the clinical use of atrioventricular "sequential" pacemaker, it can be anticipated that more episodes of right-sided diaphragmatic sound may be seen, especially since there is usually great difficulty in maintaining the anatomic position of the right atrial pacemaker electrode.[6]

Finally, the electrocardiogram, and perhaps a phonocardiogram with apex cardiogram, will ultimately clarify the diagnosis which will already be accomplished by the astute and alert clinician.

Summary

Physical findings in cardiac disease have achieved renewed validity and scientific basis over the last 15 years. The introduction, during the past decade, of electronic cardiac pacing devices, introduces an entirely new kind of cardiac "pathology" with which the bedside clinician must deal. The observation of absence of variability of the first heart sound opens several diagnostic possibilities when one is examining a patient with an indwelling cardiac pacemaker. To properly identify the status of such a patient, one must be aware of the various types of cardiac pacemakers, their anatomic placement, sequence of depolarization, and, most importantly, potential complications.

An unusual, but not rare, clinical finding in such patients is detailed in this report. By careful examination and analysis of the various possibilities which may occur, its precise identification is permitted the clinician.

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Determination of Brain Death

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WITH THE ADVENT of organ transplantation and the development of excellent respiratory support, the determination of death is once again a problem for organized medicine. When embalming became almost universal following the Civil War, the old Victorian or infantile fear of being "buried alive" became a thing of the past. Prior to the Civil War, use of a cold mirror, cutting an artery, or three days of putrefaction might all be used to prove death. Obviously, none of these technics was entirely satisfactory. For the past several decades, the use of the stethoscope plus examination of retinal vessels for sedimentation in the column of blood have been accepted as definitive. These also are not perfect technics, partly because death does not occur at a single instant. Death of the cells in various organs can be extended over a period of minutes or hours. This, plus the remarkable technical advances in respiratory support, sometimes makes it necessary to determine whether the brain has been irreversibly damaged in a body in which other fundamental organs still function. This article reviews some of the principles currently employed in such determinations, using sources so varied that precise attribution is difficult. Many hospitals have now devised protocols, all similar to that in Table I.

The clergy, lawyers, and the population at large have relegated the responsibility for the determination of death to the physicians. If a physician is indeed responsible, then ideally the determination of death should be by that physician who is most directly responsible for the patient's care and welfare. In determination of brain death, however, the personal physician may find it desirable to call for the opinion of an independent consultant. In many institutions, a neurologist or a neurosurgeon may very well be involved, but there is no professional or legal reason why such a specialist is required.

One prime reason for the determination of brain death has to do with organ transplantation. Nevertheless, there are other times when, in an effort to avoid unnecessary grief, prolonged uncertainty and economic disaster, the personal physician with or without a consultant decides not to prolong the act of dying. It must be remembered that in most instances, when the brain is irreversibly damaged, the heart gradually stops beating within a few days. For this reason plus legal uncertainties, some responsible physicians will decide never to "declare brain death." Nature will eventually decide for them in most instances. This article is intended less for those physicians than for practitioners who feel any unnecessary prolongation of a hopeless situation is not in the patient's interest.

Two typical examples are presented.

Case 1. — This 8-year-old boy was in an automobile accident and hit his head, though he sustained no gross fracture. Almost immediately after the accident, spontaneous respiration failed and the blood pressure was sustained artificially. Although decerebrate, and having grand mal

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seizures immediately after the trauma, within two hours he became flaccid and was without response to stimulation. His situation then conformed to most of the criteria of brain death as outlined in Table I. The electroencephalogram (EEG) was iso-electric. Nevertheless, bilateral ankle jerks and bilateral triceps reflexes were noted at times, although 12 hours after the initial EEG, these also disappeared. After a second iso-electric EEG, the family was informed that his brain was dead, and after removal of a kidney for transplantation, respiratory support was discontinued.

Except for the anguish involved, clinical decisions were easy in this case.

Case 2. — This 58-year-old white, male, hypertensive patient was apparently in good health with the exception of blood pressure as high as 240/120 mm per Hg. While in the toilet, he was heard to cry out and was found lying in an unresponsive condition. His neck was supple, his pupils were pinpoint, and his reflexes were hyperactive. Within several hours, respiratory support was required, the spinal fluid contained fresh blood and was xanthochromic. Marked spontaneous fluctuations in body temperature occurred. Two days after admission, it was noted that the right pupil was dilated and fixed. After 28 days of respiratory support, he still had reflexes at the ankles, biceps, and knees but absolutely no other response of any kind with the exception of infrequent and weak sucking movements around the tube in his mouth. Respiratory support was halted. It was then discovered that he breathed spontaneously, though the breathing was ataxic. Intravenous feedings were discontinued, and he died 24 hours later.

This case is an example of the problem in patients who meet some, but not all, of the criteria of "brain death."

Clinical Criteria

Clinical criteria for brain death include the need to be sure that the barbiturate levels are not elevated and that the body temperature is above 90 F (32.2 C), since hypothermia or intoxication with sedatives can produce spurious EEG and clinical indications of irreversible damage. With total brain death, the pupils are large but not maximally dilated and are unresponsive to light or to a pinch of the neck (ciliospinal reflex). There is no movement of the eyes with side-to-side turning of the head, and the heart rate is unaffected by eyeball pressure. Spontaneous and evoked movements are absent. At times, deep tendon reflexes may be present, since these only indicate a functioning spinal cord. A summary of the formal and strict criteria used currently at The Ohio State University Hospitals is presented in Table I. This table includes most of the features currently accepted around the nation.

Several points regarding the clinical criteria outlined in Table I are of particular interest. With temporary and reversible ischemia, the pupils may be maximally dilated although they are not irreversibly fixed. Such maximal dilatation represents a discharge from the sympathetic system and is not due to irreversible brain damage. With true death, and in brain death, the pupil is at about 7 to 8 mm and fixed, as if the third cranial nerve had been sectioned. Ice water in the ear, which is an extremely strong stimulus to the vestibular centers, produces no effect in patients with brain death. With partial damage or coma, tonic deviation without nystagmus may be noted. Another test of vestibular centers, the so-called "doll's eye" response which is elicited by rotating the head from side to side, may be exaggerated in patients with bilateral cortical damage, but with total brain damage, there should be no movement of the eyes when the head is rotated.

Laboratory Criteria

Numerous laboratory examinations for brain death have been suggested and some are outlined in Table 2. Aside from the EEG, which is the only accepted laboratory criterion, the most useful criteria would appear to be blood gas studies, comparing the venous and arterial differences in the vessels in the neck, or isotope studies. In patients with brain death, a bolus isotope scan of the brain using a rapid venous injection may show no initial uptake of the radioactive material in the cerebral hemispheres due to edema or secondary

TABLE 1. Criteria Used for Determining Death at The Ohio State University Hospitals

A. Unofficial criteria

1. No hypothermia (temp below 90 F or 32.2 C) or significant depressant drug levels.
2. No reflexes, spontaneous breathing, or muscle activity.
3. A flat EEG at gains of 50 uv/10 mm to 15 uv/10 mm through a minimum of 20 minutes of recording.
4. No clinical or EEG response to noise or pinch.
5. Presence of criteria Nos. 1, 2, 3, and 4 after 12 hours.

B. Clinical data that should be recorded

1. Temperature
2. Barbiturate level
3. Heart rate
4. Movements: spontaneous and evoked (severe pain, noise)
5. Eyes: position plus response to head turning and to caloric testing
6. Pupils: size and reaction to light and nuchal pinch
7. Reflexes: deep tendon plus Babinski sign.

Table 2. Laboratory Data Which Might Be Abnormal with Brain Death

1. EEG (iso-electric)
2. Arteriogram (nonfilling)
3. Bolus scan with radioisotope (nonfilling)
4. Cerebrospinal fluid: pH (lowered)
   Lactic acid (increased)
   pO_2 (reduced)
   pCO_2 (increased)
5. Difference in jugular, venous, and carotid artery oxygen content (little change in patients with brain death)
6. Effect of atropine or cardiac stimulators on heart rate.

to shunting of blood past areas of microclots and local circulatory arrest. We have been interested recently in changes of materials in the spinal fluid in patients with brain death. Alteration of the cerebrospinal fluid (CSF) constituents, such as an increase in lactic acid, may eventually turn out to be another simple measure of irreversible and severe brain damage. Surprisingly, there is usually not an increase in CSF pressure in these patients. These criteria, and additional still undiscovered physiologic changes, can never replace the necessity for a clinical determination, however.

The patient's physician should have a definite and clear plan when the determination of brain death is made. It seems improper to expect a family to make the decision about cessation of respiratory support, but they must be carefully informed regarding the procedures and decisions. It is my opinion that if the patient has had irreversible brain death, and after sufficient time has elapsed for the family to become accustomed to this thought, the physician should actively discontinue all respiratory support. If such an approach is not intended, there is no reason to employ the various criteria listed in the tables.

Major questions remain, and others will become apparent as these unfortunate patients are seen. All too many patients will not fit any exact "criteria," and scrupulous clinical judgment cannot be replaced by a check sheet. What about one or two reflexes being present? The minimum time required for assessment may well be less than 12 hours, but this type of detail also needs extensive research and evaluation. Another fascinating problem is the issue of why blood does not flow through these severely damaged brains. Increased cerebrospinal fluid pressure is not the sole explanation, since not all the patients have cerebral edema. Endothelial thickening and clots in the microcirculation may be factors. If so, is there a preventative, or a therapeutic approach we have not yet glimpsed?

Such theoretical questions are small comfort in the midst of day-to-day clinical uncertainties. It is hoped that this discussion will clarify rather than obfuscate this problem for practitioners, and their practices and observations may well help to set the standards in management of these unfortunate patients.

CARDIOVASCULAR EFFECTS OF PERITONEAL INSUFFLATION. — We have investigated, in 13 artificially ventilated and anesthetized patients, the cardiovascular effects of peritoneal insufflation of carbon dioxide preparatory to laparoscopy. Stepwise increases of intra-abdominal pressure up to a maximum of 25 cm H_2O were accompanied by increases of airway pressure, intrathoracic pressure, central venous pressure, and femoral venous pressure and by signs of cardiovascular stimulation with mild tachycardia and hypertension. End-tidal carbon dioxide tension rose only slightly. The anesthetic technique used provided good surgical conditions; our results suggest that it does not impose undue strain on the homeostatic ability of the patient's cardiovascular system. — I. Smith, R.C.O.G.; R. J. Benzie, M.R.C.G.P.; Nanette L. M. Gordon, F.F.A.R.C.S.; et al, Aberdeen, *British Medical Journal* 3:410-411, 1971.

Test That Baby's Hearing

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CAN YOUR NURSE spare two minutes? That's all the time it takes to screen a young child's hearing. Hearing loss, unlike a speech defect, is often not evident, and detection varies with the severity of the defect and the age of the child. Equally important is the suspicion of deafness by the parents and physician. Clinical experience, although confirming the high reliability of parental suspicion concerning the responsiveness of their children to auditory stimuli, shows an average delay of over a year between initial parental concern and referral for assessment.[1] A loss of hearing cannot be considered as just the malfunction of a single organ, because a serious delay in the development of speech and language and loss of contact between the child, his parents, his peers, and his environment are a direct result of this hearing disorder. Severity of the total problem depends not only on the nature and extent of the lesion but also on the age of occurrence and the length of time prior to the detection. Hardy describes the first year of communicative development as a period of "readiness to listen"; and the second year of "readiness to talk"; a time during which the child advances from a "self-monitoring system" by which he compares what he says with that which he hears said through a period of "egocentric speech" in which he learns first to think in the concrete then in both abstract and creative verbal form.[2]

But why bother to detect a hearing loss early? It becomes evident eventually. The truth of the matter is that the impulse for spontaneous learning of speech reaches its peak during the first three or four years, and since the first year is the optimum time for learning to hear, lack of opportunity to learn at this critical time causes delay or failure in speech development. It has been clearly established that the majority of children with hearing disorders have residual hearing,[3] but to make this residual hearing meaningful, auditory training must start early. The end result of early detection is medical or surgical correction of the hearing loss or, in cases of sensorineural loss, the establishment of a program for auditory training and amplification. Exposure to the spoken word during the early years is essential to the learning process and to the eventual successful habilitation of a hearing impaired child.[4,5]

Over the past two decades, considerable literature has accumulated about hearing tests of infants and children. Unfortunately much of this information is in journals not generally read by the family physician or pediatrician. Yet the physician is often the first person whose advice is sought when there is a concern about the child's hearing, or he is consulted as the professional who is expected to coordinate the evaluation and therapy for hearing impaired children. It is the physician who examines the newborn infants in the hospital and provides follow-up care in his

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office or in a community health agency. His responsibility is to determine hospital practices for hearing and language assessments. He plays an important role in the organization of community health projects and evaluation of preschool children. For these reasons it is essential that the physician be as familiar with how the infant and child hears as he is with the kind of food the child eats and the immunizations he has received.

The incidence of hearing disorders among children seen in the outpatient department at the Columbus Children's Hospital is approximately 10 percent with about 80 percent of these responding to medical or surgical treatment. The incidence of a severe permanent hearing loss which requires long term therapy is approximately 1 to 2 per 1,000 children. Furthermore, infants who are so-called high risk children (Table I) have an incidence of hearing disorders 14 times that of the incidence of deafness in the population as a whole.[6] The family history of deafness, prematurity, and maternal rubella are the most common clinical occurrences that indicate the need for routine screening. Since the relative number of these children is small, they can all be tested.

Table 1. Hearing Factors Involving So-Called High Risk Children

1. **Familial**
   History of parent or sibling with sensoineural hearing loss. Genetic abnormalities associated with congenital deafness, syndromes including congenital nephritis, Klippel-Feil syndrome, Treacher-Collins syndrome, retinitis pigmentosa, and Waardenburg's syndrome.
2. **Prenatal or Intrauterine**
   Intrauterine infections, particularly rubella during first 16 weeks of pregnancy; threatened abortion, maternal anoxia, preeclamptic and eclamptic states later in pregnancy; maternal diabetes mellitus; drugs such as quinine, salicylates, and streptomycin; association with other congenital abnormalities, particularly those involving eyes, heart, or CNS; and cleft palate.
3. **Perinatal**
   Premature birth; prolonged or difficult labor; anoxia at birth; and excessive unconjugated bilirubin in blood resulting in kernicterus.
4. **Postnatal**
   Convulsions and acquired disorders of CNS; ototoxic drugs including neomycin, vancomycin, kanamycin, viomycin; acute infections, particularly mumps, measles, meningitis, and encephalitis; and recurrent URI problems, including otitis media, hypertrophied adenoids, and allergy.

Auditory Test Procedures

The administration or the supervision of audiologic screening does fall within the province of the family physician and the pediatrician. All clinical audiometric evaluations are based on the perception of sound by listeners as related to the physical properties of the sound that give rise to them. Loudness is equated with the intensity as measured by sound pressure levels in terms of the decibel (dB) and pitch with frequency as measured by pure tones in cycles per second (cps). The sophistication of the screening procedure used in the childhood age group is determined primarily by the age of the child. During the past decade auditory screening programs have been implemented in some newborn nurseries throughout the United States. With infants from birth to 4 months, intense sound stimulation (70 to 100 dB) at cribside is used to elicit a startle reaction or a cessation of activity. This type of response is an automatic withdrawal or reflex response to a potentially harmful stimulus.[7] Review of data from the limited number of controlled studies reported has demonstrated unfortunately that routine screening of newborn infants for hearing has not been perfected as a reliable screening procedure. The test is either not sophisticated enough or the newborn infant is too immature to be tested by a pure-tone apparatus and to be observed for his gross responses to sound. A recent statement published by The American Academy of Pediatrics in conjunction with the American Academy of Ophthalmology and Otolaryngology and the American Speech and Hearing Association, states that although they recognize the urgent need for early detection of hearing impairment, they cannot recommend routine screening of newborns for hearing impairment.[8]

However, testing a child from age 8 months to 14 months is where the physician can really be of great assistance to his patients. Information derived from testing at this age is quite reliable and can clearly tell a physician when the problem exists. Fortunately, the technic for hearing screening on a child of this age is quite simple. During the early 1960s, Hardy, et al, at the Johns Hopkins Medical Institutions, tested a modified version of the Ewing technic more than 4,000 times on infants. The tests were carefully simplified and standardized on a large group of normal infants and included whispered sounds ("sh" and "ch"), rattles, and crushing of tissue paper presented outside the visual range of the child. This testing was most efficient and not only furnished information concerning reaction to sound stimulus, but also often pointed out the children who suffered from neurologic developmental deviations. Sixty percent of those infants who failed this simple test also did poorly on psychological testing carried out at a later date.[5] It was also noted that the field of auditory awareness gradually expanded with age from one foot at 6 months of age to up to 10 or 12 feet, or average room size by age 2½ years. The technic for this test was to

seat the child on his mother's lap, facing another adult who attracts the child's attention with a toy, while a third adult would crouch behind the child, out of sight, and operate a variety of noisemakers. The hearing child is distracted by the sound and responds by turning his head or eyes toward the sound. A modification of this technic was reported from the Permanente Clinic by Callas and Callas and consisted of replacing the adult behind the child with an inexpensive stereophonic tape recorder.[9] Various noisemakers including a cricket, bell, pitchpipe, and human voice were recorded alternately on the right and left channels of the tape recorder. Playback volume is adjusted so that the reproduced sounds are not as loud as the original noisemakers, to minimize spurious responses as well as playback distortion. The sequence of sounds presented is random to maintain the child's interest and minimize adaptation to the stimuli. The children were tested in a multipurpose room with the door closed to reduce environmental noise and visual distractions. The tape recording was about 20 seconds long with an initial silent period of 6 seconds. The entire test required only a few minutes including the time spent explaining the procedure to the mother. They noted that testing is best done before the child is undressed and weighed so that he is less likely to be upset or crying. The children's responses were reportedly most clear-cut if the nurse avoided attracting the child's attention.

This simplified testing of the young child has many strong points. First, this technic tests a child who is too young for conventional audiometry. Second, it can be performed by a variety of personnel. Third, the responses are clear-cut and are not dependent upon the child's comprehension of test directions. Fourth, the response that is elicited, the turning of the head in order to search out the sound, is a basic neurologic reflex which, when present, clearly demonstrates that the child has sufficient auditory acuity to develop language. This testing procedure can be reproduced and standardized and repeated ad infinitum without difficulty, with little expense, and without intensive training. It should be performed routinely on all children between the ages of 8 to 14 months. A child who fails this screening test should have a careful physical examination including otologic examination and developmental history. Depending upon the results of these evaluations pure tone audiometry performed by an audiologist may be the next step for more definite testing.

The Ohio Department of Health Program

The Ohio Department of Health has developed screening programs in some areas of the State utilizing the Hardy adaptation of the Ewing test. This screening procedure is designed for testing the 8- to 14-month-old infant. Also, they offer consultant service to any individuals who wish to develop infant screening services. Parent groups and voluntary organizations have begun this testing in a few cities in Ohio. Whenever a child fails this test he is referred for follow-up to an audiologist. A five-minute, 16 mm film entitled "Auditory Screening Tests for Infants," has been prepared by the Ohio Department of Health to demonstrate the screening test and to teach interested people.

Conclusion

The password of medicine for the 1970s is to deliver better health care to more people. Each physician who sees children has the responsibility and the opportunity to detect auditory impairments in young children in this simple and inexpensive manner. The Hearing and Vision Conservation Unit of the Ohio Department of Health has accepted this responsibility and has developed programs for the training of nurses and laymen to do hearing screens in the community. When contacted, they are most willing to assist your office or your clinic in establishing this reliable procedure. Won't you please take the time to institute this practice of testing hearing in infants in your office?

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Rickets, American Style

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RICKETS is seldom a matter of nutritional or climatic deprivation in most parts of the United States. The occasional child we see with classic rickets—by x-ray film and bone biopsy—probably represents one of a number of disorders characterized by loss of calcium or phosphorous in the urine, grouped under the heading of tubular disorders. The term indicates the primary fault to lie in impaired tubular reabsorption of calcium or phosphorous without abnormality in the glomeruli or the glomerular filtration of these solutes. The result, for the bones, is exactly the same as old fashioned, avitaminosis D. The prognosis for the child lies not in the bone disease but in the associated renal disease which may lead to renal failure. It is possible to describe briefly the more common tubular syndromes leading to rickets as follows:

1. Renal Tubular Acidosis
   Rickets, nephrocalcinosis, nephrolithiasis, metabolic acidosis with alkaline urine, hypokalemia.
2. Fanconi Syndrome
   Rickets, amino-aciduria, glycosuria, progressive renal insufficiency.
3. Vitamin D Resistant Rickets
   Rickets, glycosuria, familial occurrence.

The clinician must be alert to the diagnostic clues provided by such signs as glycosuria or nephrocalcinosis.

These syndromes will often respond to massive doses of vitamin D so far as the rickets is concerned. For example, 50,000 units per day may be required in place of the 1,500 to 5,000 units used to treat nutritional rickets.

Two points remain. The first is that the loss of calcium from the body may also take place via the gastrointestinal tract. Thus, malabsorption is also a cause of rickets. Secondly, the bone disease associated with chronic uremia has been called "renal rickets," although it is predominantly secondary hyperparathyroidism rather than rickets. Modern usage would suggest that the term renal rickets be abandoned. Tubular disease with rickets satisfactorily describes the one group, and uremic osteodystrophy, the other. In any case, rickets for the American doctor means—think kidney!

*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.

ACHILLES TENOTOMY was performed on 66 limbs in 60 patients with severe intermittent claudication and the results were assessed two years later. Early improvement occurred in half of them but decreased to 17 percent two years postoperatively. Sympathectomy did not influence the result. The postoperative morbidity was 14 percent, and 21 percent of limbs were subsequently amputated. The late mortality in the group studied was 8 percent. — S. J. A. Powis, F.R.C.S.; J. S. Skilton, F.R.C.S.; F. Ashton, F.R.C.S.; and G. Slaney, F.R.C.S., Birmingham, England, *British Medical Journal* 3:522-523, 1971.

Discussion of E.N.T. Case of the Month

(continued from p. 28)

The most likely diagnosis would be sialolithiasis with secondary sialadenitis of the submaxillary gland. This diagnosis can be confirmed by probing the duct with a small lacrimal cannula and palpating the stone.

If probing is not practical, radiographic examination should be done. Ninety percent of the calculi occurring here are radiopaque and can be identified on routine scout films. Large stones located within the hilum of the gland are best seen with a lateral view of the neck (Fig. 2). However, a small stone located within Wharton's duct would be hidden in this view by the dense bone of the mandible. These small stones can be identified with the dental occlusive view which views the floor of the mouth from below (Fig. 3).

If the scout films are negative, a sialogram should be done. This injection of a contrast medium into the salivary duct will outline nonopaque stones.

The treatment depends upon the size and location of the calculus. Small stones located within Wharton's duct may be removed through a small incision in the floor of the mouth, usually an office procedure. Large stones located within the hilum require excision of the entire gland.



FIG. 2. Arrow points to large stone located in hilum of submaxillary gland.



FIG. 3. Dental occlusive view shows small stone in Wharton's duct (arrow).



CAMPBELL'S SOUPS IN DIABETIC DIETS*

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* These recommendations are based on a *one cup portion* when prepared according to directions on the label. If milk is used in the preparation, use part of your daily requirement.

Exchange Substitution for 1 Bread and ½ Fat

Tomato
Tomato, Bisque of
Tomato Rice Old Fashioned

Exchange Substitution for ½ Bread and ½ Fat

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Exchange Substitution for 1 Meat and 1½ Bread

Hot Dog Bean
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Exchange Substitution for ¼ Meat and ½ Bread

Chicken Gumbo
Chicken Noodle

Campbell's Soups are appetizing and enjoyable and, because of the many varieties available, offer your diabetic patients the opportunity to plan and enjoy more interesting and appealing meals.

*To obtain copies of "Recommendations for Placing Campbell's Soups Into Exchange Lists," suitable for distribution to patients, write to Campbell Soup Company, Dept. 500, Campbell Place, Camden, N.J. 08101.

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It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. *Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.*

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TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
Diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: may be habit-forming)
Atropine sulfate . . . . . 0.025 mg.

Saves the Day

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is classified as a Schedule V substance by Federal Law with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages



should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended average initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo....½ tsp.* t.i.d. (3 mg.)
6-12 mo...½ tsp. q.i.d. (4 mg.)
1-2 yr.....½ tsp. 5 times daily (5 mg.)
2-5 yr.....1 tsp. t.i.d. (6 mg.)
5-8 yr.....1 tsp. q.i.d. (8 mg.)
8-12 yr....1 tsp. 5 times daily (10 mg.)
Adults:....2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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Testimony on the Malpractice Crisis

Ohio Physician Among Those Who Testify Before HEW Commission on Medical Malpractice at Regional Meeting in Cincinnati

By Walter A. Daniel, M.D.

MY NAME is Dr. Walter A. Daniel. I am a physician, and have been practicing in Tiffin, Ohio since 1946. I am engaged in general practice and also perform surgical, obstetrical and anesthesiological services. Since 1969, I have been the chairman of the Committee on Insurance of the Ohio State Medical Association. A primary function of our committee is to study and recommend to the OSMA Council and House of Delegates programs and activities in some of the areas with which this Commission is generally concerned and, in particular, the areas of (1) the cost and availability of professional liability insurance and (2) the review and improvement of mechanisms and procedures used in adjudicating medical malpractice claims and (3) the study of the impact of legal doctrines upon such adjudications.

To state that there is a "crisis" today in the medical malpractice situation is to state the obvious. The Commission has already heard in some detail at its earlier meeting in Los Angeles evidence of some of the extraordinary increases in recent years in the number of medical malpractice claims and the equally extraordinary rise in premium costs charged by the liability insurance carriers who are, in shrinking numbers, offering professional liability protection to the nation's physicians. So that there may be no question that these national trends are present also in Ohio, let me give a personal example.

My professional liability insurance for $100,000-$300,000 protection cost me $126.00 in February of 1966. In February of 1971, five years later, I wrote a check for $1,334.00 for the same coverage. This is an increase of approximately 1,100 percent in a period of five years. You have already heard testimony in Los Angeles of even larger premium increases.

I have not come here today, however, merely to add to the "list of horribles" which has been and undoubtedly will continue to be paraded before you in these regional meetings. Our Chinese friends, old and new, have for centuries used two characters to write the word "crisis." The first is "danger"; the second is "opportunity." I would like to comment briefly upon the former and then focus upon one of the opportunities which we of the Ohio State Medical Association believe holds great promise in correcting one of the principal excesses and dangers in the current professional liability situation.

Some of the dangers in the present situation are fairly obvious and well-known; for example, the over-utilization of laboratory and other tests in the practice of "defensive medicine." It is equally obvious that this situation leads directly to higher costs for the consumer and for the third-party indemnitors of providers of medical and health care services.

A further danger, perhaps not so obvious but equally significant, is the deterioration in the physician-patient relationship which is resulting from the present crisis. All too often the physician and patient eye one another as potential litigants with the result that the trust and confidence between physician and patient which is so necessary, not only to sustain the relationship but literally to "heal the patient," is becoming increasingly difficult to establish and maintain. In my view and in that of our Committee, one of the principal obstacles to the creation and maintenance of healthy physician-patient relationships is the use, or perhaps more accurately, the misuse of the legal doctrine of "informed consent."

While the legal doctrine of "informed consent" may be merely old wine in new bottles, it can hardly be disputed that its use in recent years by the plaintiff's bar as a vehicle to prosecute medical malpractice claims against physicians has risen rapidly. Our legal counsel reported one conversation to our Committee which he had had recently with another attorney who was of the opinion that any plaintiff's lawyer who did not include an "informed consent" claim in a medical malpractice case was himself guilty of malpractice in representing the patient! The proliferation of these "informed consent" claims has caused our Committee and the Ohio State Medical Association to study the legal doctrine of "informed consent" in depth and particularly its impact upon the physician-patient relationship. We believe sincerely that an opportunity exists both to reshape

This article, with minor editorial changes, is the text of remarks made by Dr. Daniel to the Commission on Medical Malpractice, appointed by the Secretary of HEW, at its Regional Meeting in Cincinnati, November 13, 1971. Dr. Daniel is a practicing physician in Tiffin and is chairman of the OSMA Committee on Insurance.

the doctrine to suit better the practical needs of today's society and also to serve better the interests of both the physician and patient.

The opportunity which a reformation of the "informed consent" doctrine offers is, in our judgment, to bring the relationship between physician and patient into better balance. Let me be clear as to one point. The physicians of Ohio by and large recognize that the existence and use of the "informed consent" doctrine in professional liability litigation is a healthy brake upon the tendency of some of our colleagues to believe that "the doctor always knows best" when it comes to the matter of the treatment which the patient should receive. We in the medical profession are coming to recognize with increasing understanding that the patient has a legal and moral right to decide for himself, based upon a reasonable explanation of the hazards, risks and alternate methods of treatment, given to him by the physician, whether or not he will or will not submit to a particular course of medical treatment.

By the same token, it is clear that something must be done to protect the physician from the specter of being sued whenever he accepts a person as his patient and, in particular, when the treatment which he tenders or the procedure which he performs ends with unfortunate or tragic results. It is of course these situations when the patient is most likely to cry to his lawyer, "But the doctor never told me that this (result) could happen!"

Unless we are to face the prospect of having every conversation between physician and patient made the subject of a video tape interview, complete with TV cameras and microphones in the doctor's office (a wild prospect to some, but not unlike the proposals advanced by some people following certain decisions by the U.S. Supreme Court with respect to the interrogation of criminal suspects by police) we must develop some short-form method of preserving the patients' consent to treatment once he has been informed by his physician of its nature and of any potential hazards. If we do not, the physicians will continuously be harassed by lawsuits in which the claims of patients will be heard daily in the court rooms that the doctor did not explain the situation fully to his patient. The physician is then placed in the untenable and probably indefensible

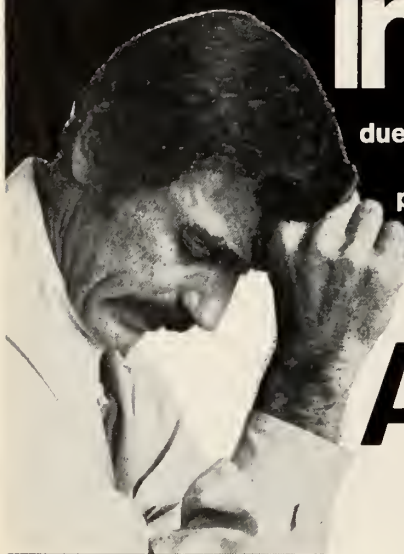
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The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Each yellow tablet contains:
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Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
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Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.
Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone thyroid compound. West Med 5:67, 1964. 3. **Tiroff, A. S.** Methyltestosterone-thyroid in treating impotency. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:930, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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(to a judge or jury) position of meekly explaining that it is "his usual practice" to explain such risks and hazards of treatment to his patient but that, because it has been two years since he held the conversation with the patient and because he has seen countless other patients in the interim, he cannot state flatly that he held such a conversation in **that** case with **that** patient.

To provide the necessary protection to the physician from harassment of these claims and to redress the evidentiary balance now existing so markedly in favor of the patient, the Ohio General Assembly is now considering a bill, S.B. 242, which would enable both the physician and the patient to have a written record of their conversation regarding the proposed treatment that would, except in certain instances, be conclusive. A copy of S.B. 242 is attached. (Exhibit "A").

Senate Bill 242 was supported by the Ohio State Medical Association and the Ohio Hospital Association, but was vigorously opposed by the plaintiff's bar in Ohio.

We would like also to bring to the Commissions's attention a proposed bill which has been prepared by our Committee and which will be introduced in the next session of the Ohio General Assembly. A copy of that proposed bill is attached (Exhibit "B") and the Commission will note that it takes a somewhat different approach to the problem of "informed consent" from that in S.B. 242, but it is likewise an attempt to deal straightforwardly and reasonably with the problem by specifying the burden of proof that must be met in the courts of law in any "informed consent" case.

We urge the Commission to study carefully the "informed consent" problem and we offer these comments and proposed legislative alternatives to the Commission in the spirit of constructive problem-solving.

In closing, we would strongly suggest to the Commission that it recommend to Congress and to the several states some legislative modification of the "informed consent" doctrine which, as I have tried to point out, has unfortunately operated to cause further deterioration of the physician-patient relationship, has complicated the process of rendering medical services and treatment, and has contributed to the increased cost of delivering quality medical care. The consequences both

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DESCRIPTION: Methyltestosterone is 17(-Hydroxy-17-Methylandrost-4-en-3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpuberal cryptorchism	30 mg

HOW SUPPLIED: 5, 10, 25 mg in bottles of 60, 250.

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present and future, of the current situation are obvious both medically and legally, and therefore any effort to place the physician-patient relationship on a new, healthier basis, as we have proposed should be given the highest priority.

Other "opportunities" created by the current medical malpractice crisis that are currently being studied by our Committee and the Ohio State Medical Association include (1) the use of arbitration or mediation procedures to dispose of medical malpractice claims, (2) the use of "no-fault" concepts to handle medical malpractice claims and (3) the use of group insurance plans and programs to reduce the cost and enhance the availability of professional liability insurance for physicians in Ohio, and (4) peer review. However, time does not permit me to discuss our efforts regarding these studies at any length.

I shall be happy to try to answer any questions which the members of the Commission may have.

EXHIBIT "A"

109th GENERAL ASSEMBLY,
REGULAR SESSION,
1971-1972

S.B. No. 242

MESSRS. COOK-MATIA-CORTS

A BILL

To enact section 2305.26 of the Revised Code, relative to proof of patients' consent to medical or surgical treatment.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That section 2305.26 of the Revised Code be enacted to read as follows:

Sec. 2305.26. In a civil action brought against a doctor of medicine or doctor of osteopathic medicine and surgery licensed under Section 4731.14, 4731.29, 4731.291, or 4731.292 of the Revised Code, based on an allegation that the doctor examined, treated, or performed surgery on a patient without the patient's consent, a properly executed instrument in the following form or a substantially similar form shall be deemed conclusive proof of the informed consent of the person signing the instrument to the treatment stated therein, unless it can be shown that the instrument is invalid due to duress, undue influence, fraud, or incapacity of the person signing:

"Authorization for medical or surgical treatment

Date: ..... 19.... Time.....M.

I, ... A patient in
(patient's name)

..... Hospital,
hereby authorize Dr. .....
(and whomever he may designate as his assistants)
to administer such treatment as is necessary, and to perform the following operation .....
..... and such
(name of operation or procdeures)
additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said operation. I also consent to the administration of such anesthetics as are necessary, with the exception of
.....
(none, spinal anesthesia, or other)
Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice.

I hereby certify that I have read and fully understand the above authorization for medical and/or surgical treatment, the reasons why the above-named treatment, operation and/or procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. .....
I also certify that no guarantee or assurance has been made as to the results that may be obtained.
Witness..... Signed.....
(patient or nearest relative)
Witness .....
(relationship)

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when patient is physically or mentally incompetent."

The printed portion of such instrument shall be of such type size that it appears clearly and conspicuously.

The execution of such an instrument shall not be deemed consent to an act of negligence or a failure to meet standards of professional skill, conduct, or practice.

The failure to produce such an instrument shall not be considered evidence of a lack of consent.

This section does not apply to a medical emergency or a situation where Section 2305.23 of the Revised Code applies.

EXHIBIT "B"

A BILL

To enact section ..... relative to certain civil actions against physicians.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That section ..... of the Revised Code be enacted to read as follows:

Elements of certain civil actions against physicians.

In any civil action brought against a physician licensed in accordance with the provisions of Chapter 4731 of the Revised Code arising out of

the examination, diagnosis or treatment, by surgery or otherwise, of a patient without his informed consent, the patient shall prove:

(1) That the act or omission of the physician in undertaking to obtain the informed consent of the patient or his personal representative to the proposed examination, diagnosis or treatment, by surgery or otherwise, was contrary to and a violation of that standard of care which physicians of ordinary skill, care and diligence would have exercised under the same or similar circumstances;

(2) That a reasonable man, considering the circumstances and the actions and communications, if any, by the physician concerning the proposed examination, diagnosis or treatment, would not have understood the risks and hazards inherent in the examination, diagnosis or treatment;

(3) That the injury or death which is the subject of the action was directly and proximately caused by the examination, diagnosis or treatment rendered by the physician; and

(4) That the patient or his personal representative would not have consented to the examination, diagnosis or treatment had the risks or hazards thereof been disclosed in accordance with the standard of care which physicians of ordinary skill, care and diligence would have exercised under the same or similar circumstances.

This section shall not apply to actions against physicians in which consent to the examination, diagnosis or treatment rendered by the physician arises by operation of law.

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Mock News Media Conference Is Part of Leadership Training Seminar



Ohio State Medical Association President-Elect William R. Schultz, M.D., Wooster, stands on the "hot spot" during a mock news media conference as a part of a speakers and leadership training conference held jointly by the American Medical Association and OSMA recently in Columbus. The two-day seminar was conducted for members of OSMA Council, the OSMA delegation to the AMA, AMA specialty section delegates and alternates residing in Ohio, and county medical society executive secretaries.



Walter H. Maloney, M.D., Cleveland, delegate to the AMA House of Delegates from the Section on Otorhinolaryngology, emphasizes a point during the AMA-OSMA speakers and leadership training course in Columbus recently. Participants, through use of television taping and instant replay, were able to evaluate their own performances, both as speakers and in mock news conferences.



"Congratulations, Doctor," Mortimer T. Enright (left), director of the AMA Speakers and Leadership Training Program, is saying as he presents to Robert P. Johnson, M.D., Middletown, a Certificate of Commendation for having completed the AMA-OSMA speaking and leadership seminar held in Columbus recently. Dr. Johnson is an OSMA alternate delegate to the AMA. Mr. Enright, Robert A. Lang, Ph.D., executive secretary, Cleveland Academy of Medicine and an AMA speech consultant, and T. Stephen May, Ph.D., associate professor, radio-television-film, School of Speech, Northwestern University, conducted the seminar.

Toledo Academy of Medicine Sets Example by Establishing Scholarships

Following is the text of a letter addressed to the Executive Director of OSMA, with the suggestion that it be published in *The Journal:*

I think at the State level that you would be interested that the Academy of Medicine of Toledo and Lucas County is establishing three scholarships for needy students at the Medical College of Ohio at Toledo. Through Dr. Theron Hopple's Education and Professional Affairs Commission, we plan to establish scholarships with the help of the Medical College. We would hope that the support for scholarships would proliferate and that other county societies in Northwest Ohio would also see fit or be disposed to accomplish the same. Realistically, some of the bigger societies could support a scholarship and two or three of the smaller societies could ban together to support a student.

This type of support is needed and vital. We feel the public relations benefit from publication of this to the medical community and to the community in general are immeasurable. . . .

If other societies would be interested in ventures along a similar line, we would be glad to counsel them in the above or refer them to appropriate personnel in the Medical College. As you know, Northwest Ohio like other areas of Ohio, needs physicians. This real support can be meaningful in obtaining the same.

Sincerely,
Harry C. Mack, M.D.
President, Academy of Medicine
of Toledo and Lucas County

Continuing Education Opportunities for Physicians in Ohio

January

Introductory Course in Nuclear Medicine for Physicians — Dates upon request to Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Renal Hypertension Clinic — RMP Unit of Pittsburgh — St. Elizabeth Hospital, Youngstown, January 14, 8:00-9:00 a.m.

Family Medicine Review — Ohio Academy of Family Physicians, at the Sheraton-Columbus Motor Hotel, downtown Columbus, January 15-16 and 29-30.

A Day with the Ladies (Obstetrics and Gynecology) — Akron City Hospital, 525 East Market Street, Akron, January 19; 8:30 a.m.

Exclusion of Paternity — American Society of Clinical Pathologists at the Cleveland Clinic Educational Foundation, January 19-20.

Breast Lumps and Their Treatment — St. Elizabeth Hospital, Youngstown, 8:00-9:00 a.m. January 21; Dr. S. Ondash.

Foot Problems of the Prewalker and How to Manage — St. Elizabeth Hospital, Youngstown, January 28, 8:00-9:00 a.m.; Dr. K. Wegner.

Family Medicine Review, Ohio Academy of Family Physicians, at the Sheraton-Columbus Motor Hotel, downtown Columbus, January 15-16 and 29-30. Contact OAFP, 4075 N. High St., Columbus 43214.

February

Electromyography — Ohio State University College of Medicine, February 1-4.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

General Practice — Cleveland Clinic Educational Foundation, February 2-3.

Rheumatoid Arthritis; A Chronic Disease — St. Elizabeth Hospital, Youngstown, February 4; Dr. A. Randell.

Presentation of the Newer Concepts of Surgical Myocardial Revascularization — Fort Steuben Academy of Medicine, February 8, 8:15 p.m., Fort Steuben Motor Hotel, Steubenville; William B. Ford, M.D., Department of Surgery, University of Pittsburgh School of Medicine; One hour AAFP credit.

Hormonal Treatment of Carcinoma of the Breast — Trumbull Memorial Hospital, Warren, February 8; Olaf Pearson, M.D., of the Department of Medicine, Case Western Reserve University.

Immunology — Mt. Carmel Hospital, Columbus, February 9.

Gastroenterology — Ohio State University College of Medicine, February 9.

Thyroid Disease and Disorders of Calcium Metabolism — Cleveland Clinic Educational Foundation, February 9-10.

(Continued on Page 63)


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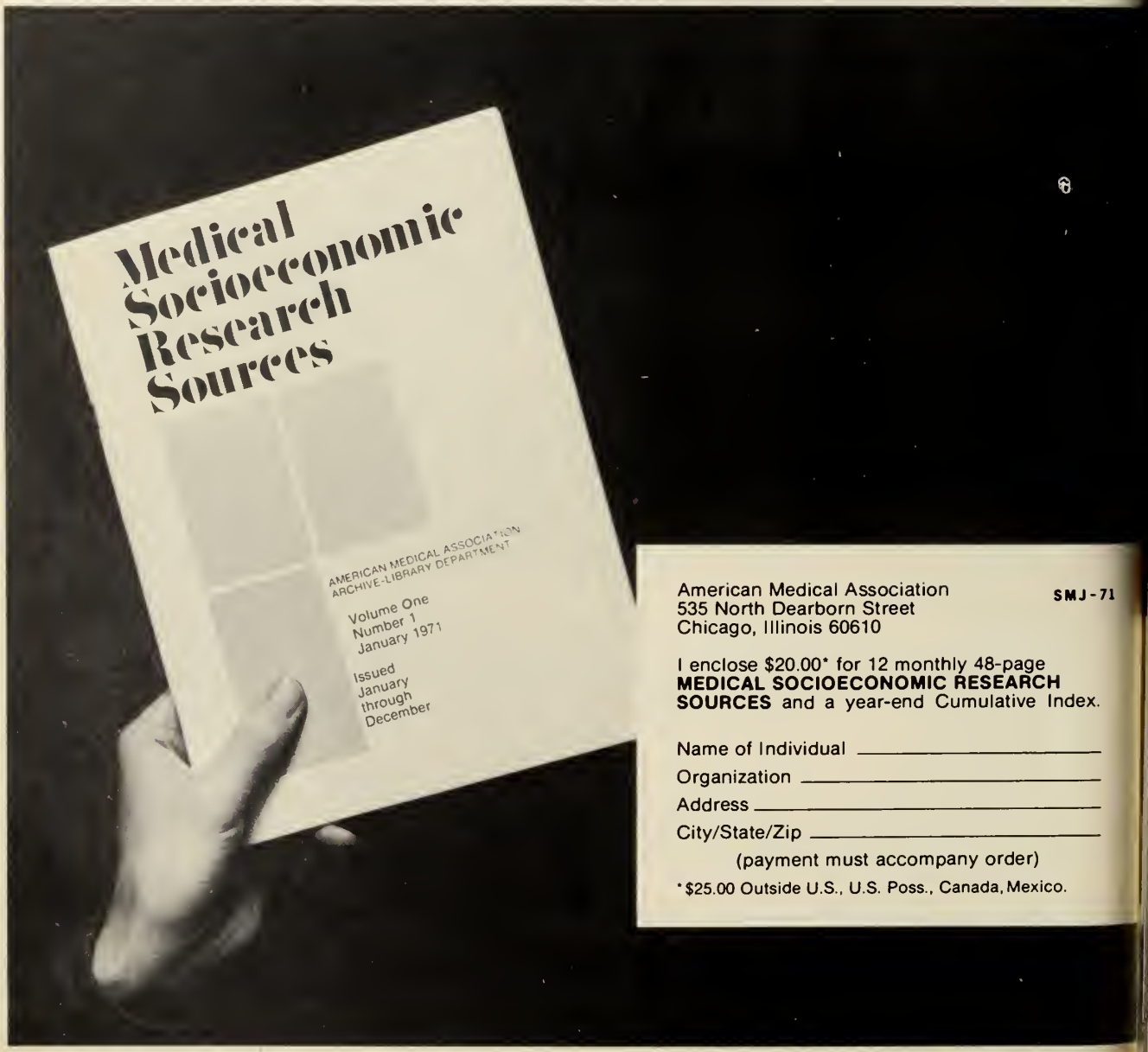
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Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
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Educational Opportunities in Ohio — *Continued*

Selected Topics in Radiological Approach to Malignant Diseases — Cleveland Clinic Educational Foundation, February 9-10.

Care of Newborn Infants — University of Cincinnati College of Medicine; CONMED, at Shriners Burns Institute, Cincinnati, February 11.

Management of Anemia; Minimum Work-Up Advisable — St. Elizabeth Hospital, Youngstown, February 11; Dr. J. Altier.

Pediatric Workshop — Indiana and Ohio Academies of Family Physicians, Hueston Woods Lodge, College Corner, Ohio, February 11-13.

Diagnostic Techniques in Coronary Artery Disease—Youngstown Hospital Association, South Unit, February 12; 4 p.m.; Drs. A. V. Whittaker and Y. P. Sheth.

Anatomy and Physiology of OB-Gyn — St. Ann Hospital, Cleveland, February 12.

Medical Pearls — Akron City Hospital 525 E. Market Street, February 16, 8:30 a.m.; Marvin J. Sakol, M.D., coordinator.

Internal Medicine — Ohio State University College of Medicine, February 16.

ENT — Ohio State University College of Medicine, February 17.

Headaches — When Are They Serious? — St. Elizabeth Hospital, Youngstown, February 18; Dr. R. Gilliland.

Diagnostic Laboratory Seminar—Ohio Academy of Family Physicians, and Consolidated Biomedical Laboratories, Inc., at Imperial House, North, Columbus, February 19-20.

Treatment in Psychiatry—Theory and Practice — Veterans Administration Hospital, Brecksville, February 21-25.

Learning Disabilities and the Physician — Cleveland Clinic Educational Foundation, February 23.

Advances in Orthopaedic Surgery — Cleveland Clinic Educational Foundation, February 23-24.

Fourth Annual Infectious Diseases Seminar — Sponsored by CONMED in cooperation with the University of Cincinnati College of Medicine, at Shriners Burns Institute, Cincinnati, February 24.

Respiratory Disease in Children — St. Elizabeth Hospital, Youngstown, February 25; Dr. K. Wegner.

Ophthalmology — Ohio State University College of Medicine, February 28-29.

Surgical Treatment of Coronary Artery Disease — Youngstown Hospital Association, South Branch, February 28, 4 p.m.; Drs. J. J. Turner and M. P. Bhatti.

March

Allergy—When to Test. Is Drug Therapy Helpful in the Long Term?—St. Elizabeth Hospital, Youngstown, 8-9 a.m. March 3.

Pediatric Clinic Day—Columbus, March 8; contact Ohio State University, Center for Continuing Medical Education, 410 W. 10th Street, Columbus 43210.

Renal Hypertension Clinic—by RMP Unit of Pittsburgh at St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 10.

A & B Blockers and A & B Stimulators (Pharmacology Series) — Youngstown Hospital Association, March 13.

Orthopaedic Rehabilitation—At the Hollenden House, Cleveland, March 13-15; sponsored by the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Illinois 60611.

Diagnosis and Management of Hypoglycemia —Trumbull Memorial Hospital, Warren; noon program, March 14; to be presented by James Craig, M.D., and or Bernard Landau, M.D., of Case Western Reserve University.

Infectious Diseases—OSU College of Medicine, March 14; contact Center for Continuing Medical Education at the College.

Some Aspects of Diuretic Management—Fort Steuben Academy of Medicine, March 14, at 8:15 p.m., Fort Steuben Motor Hotel, Steubenville; guest speaker, E. Gordon Margolin, M.D., well-known Cincinnati specialist in internal medicine, renal diseases, and electrolytes.

Fifth Intercontinental Conference on Diagnostic Medicine — Hawaii, March 14-18; for details contact Ohio Academy of Family Physicians, 4075 N. High Street, Columbus 43214.

Detection of Australian Antigen—Cleveland Clinic Educational Foundation, March 15-16; co-

sponsored by the American Society of Clinical Pathologists.

Seventh Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 15-16; Marvin J. Sakol, M.D., coordinator.

Advances in Urology—Cleveland Clinic Educational Foundation, March 15-16.

Veterans Administration Hospital Annual Seminar—VA Hospital, Cincinnati, March 16; Gene Conway, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

G. I. Bleeding—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 17.

Diagnosis and Repair of Facial Fractures—Medical Center, University of Cincinnati, March 20-24; Donald A. Shumrick, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

A Lipid Tutorial—Cleveland Clinic Educational Foundation, March 23-24.

Examination of the Newborn; Cardinal Points of the Examination—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 24.

Huntington Chorea Association—OSU College of Medicine, Columbus, March 26-29; contact Center for Continuing Medical Education, at the University.

Isotopes in Clinical Medicine (Pharmacology Series)—Youngstown Hospital Association, March 27.

ENT Emergencies—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 31.



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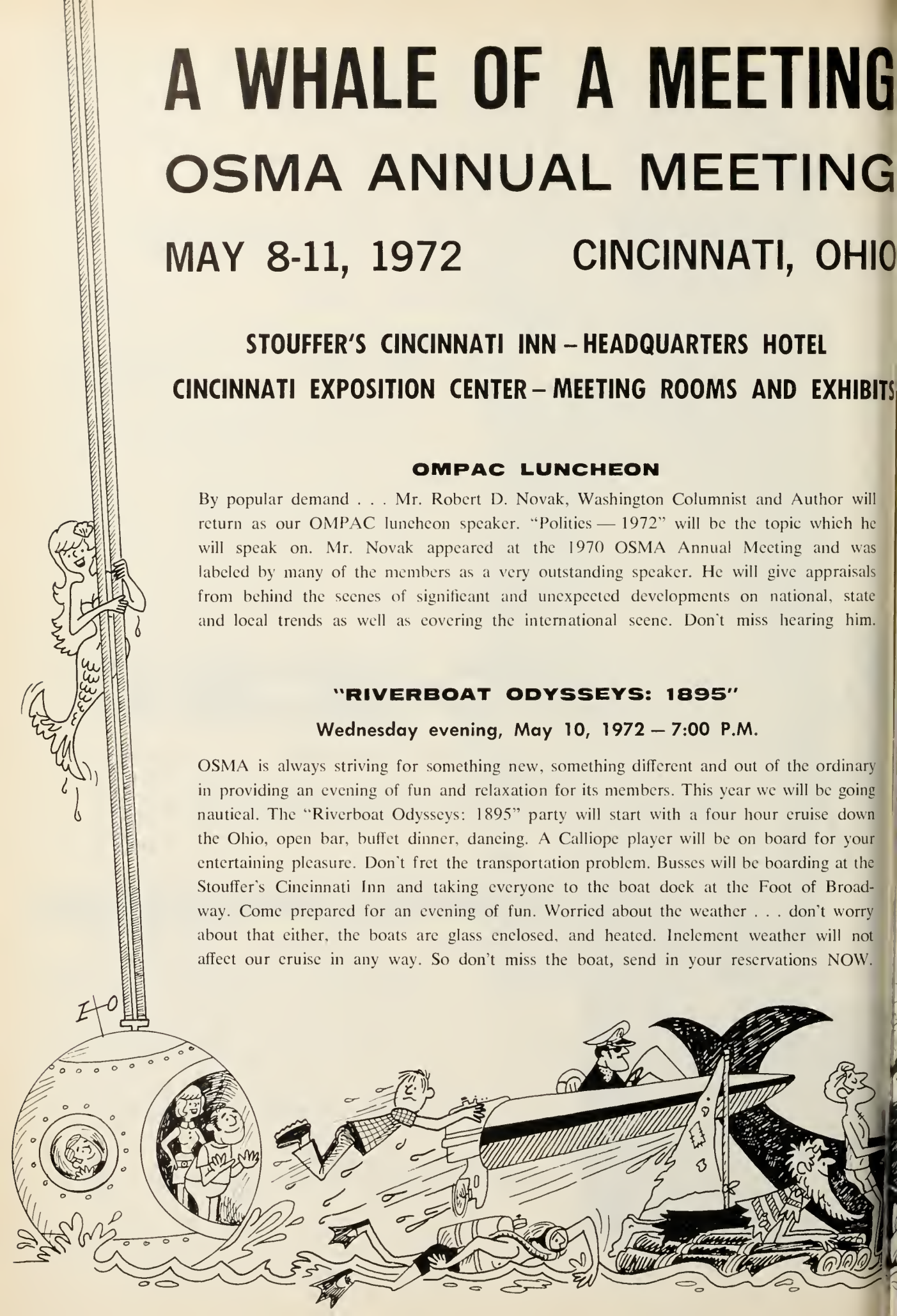
OMPAC LUNCHEON

By popular demand . . . Mr. Robert D. Novak, Washington Columnist and Author will return as our OMPAC luncheon speaker. "Polities — 1972" will be the topic which he will speak on. Mr. Novak appeared at the 1970 OSMA Annual Meeting and was labeled by many of the members as a very outstanding speaker. He will give appraisals from behind the seenes of significant and unexpeeted developments on national, state and local trends as well as eovering the international seene. Don't miss hearing him.

"RIVERBOAT ODYSSEYS: 1895"

Wednesday evening, May 10, 1972 – 7:00 P.M.

OSMA is always striving for something new, something different and out of the ordinary in providing an evening of fun and relaxation for its members. This year we will be going nautical. The "Riverboat Odysseys: 1895" party will start with a four hour cruise down the Ohio, open bar, buffet dinner, daneing. A Calliope player will be on board for your entertaining pleasure. Don't fret the transportation problem. Busses will be boarding at the Stouffer's Cincinnati Inn and taking everyone to the boat dock at the Foot of Broadway. Come prepared for an evening of fun. Worried about the weather . . . don't worry about that either, the boats are glass enclosed, and heated. Inelement weather will not affeet our cruise in any way. So don't miss the boat, send in your reservations NOW.



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PRE-REGISTRATION

All persons pre-registered may pick up their badge, program and tickets for OMPAC luncheon and "Riverboat Odysseys: 1895" party at the pre-registration desk in your name. Clip the coupon, fill out the information requested along with your **check in the proper amount** so that we may reserve tickets for you. This one step now will save you time later.

Annual Meeting Pre-Registration and Ticket Form

SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to: Ohio State Medical Association

Mail this form to: Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215

Wednesday, May 10, 11:30 A.M.

"OMPAC Luncheon"

Cincinnati Exposition Center

$5.00 per person

Number_____

Wednesday, May 10, 7:00 P.M.

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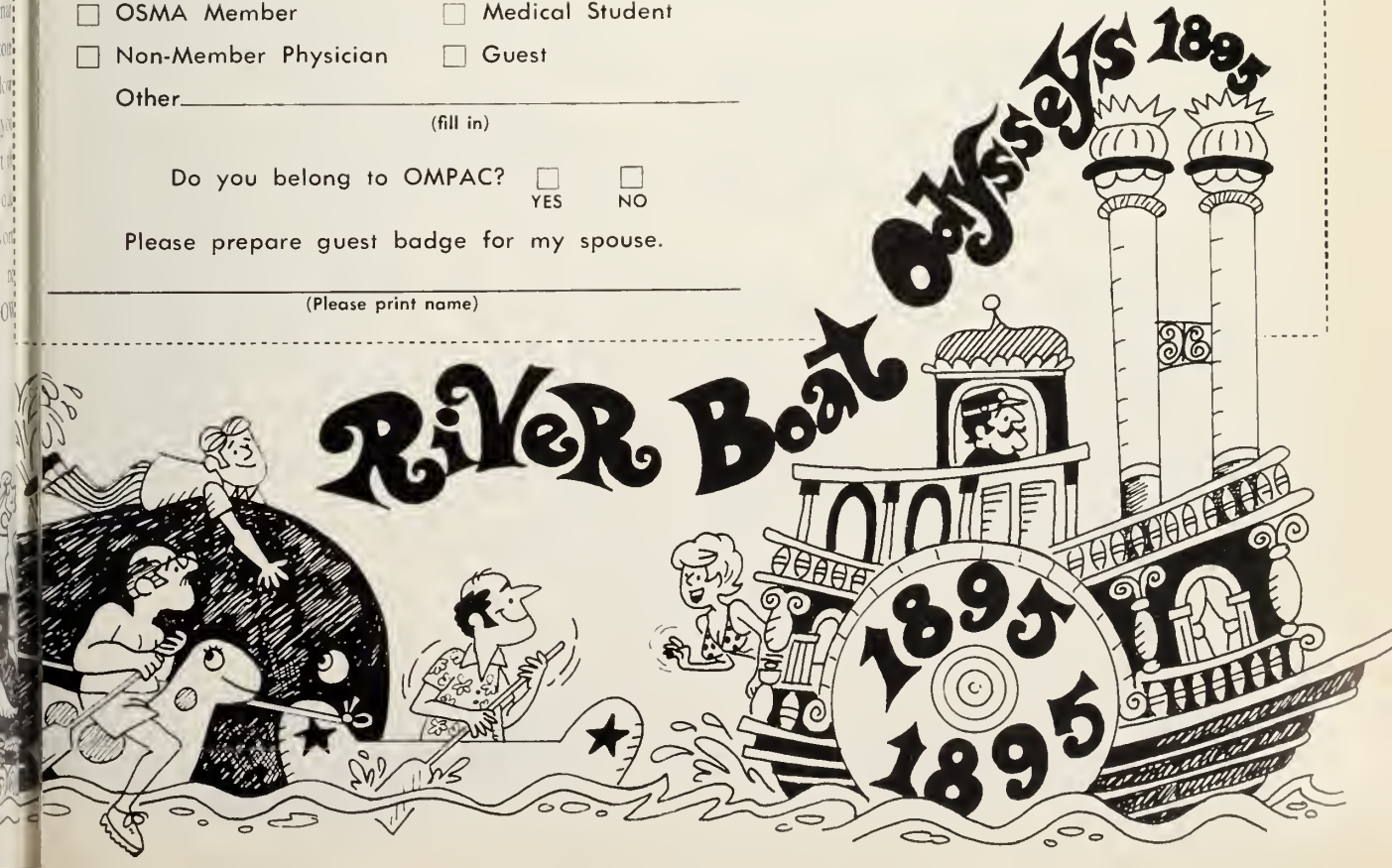
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Do you belong to OMPAC? ☐ YES ☐ NO

Please prepare guest badge for my spouse.

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Obituaries

George Louis Beyer, M.D., Toledo; Toledo Medical College, 1913; aged 80, died November 15; resident of Toledo and practitioner there before his retirement in 1946.

David John Bradley, M.D., Cincinnati; Ohio State University College of Homeopathic Medicine, 1922; aged 75; died November 9; member of OSMA, AMA, and American Academy of Pediatrics; Fellow, American College of Cardiology; diplomate, American Board of Pediatrics; practicing pediatrician in Cincinnati before his retirement; formerly on faculty of the University of Cincinnati; veteran of World War I.

Clayton Benjamin Conover, M.D., Sidney; University of Cincinnati College of Medicine, 1943; aged 61; died October 30; member, OSMA, AMA, and American Academy of Family Practice; native of Sidney and practitioner there for virtually all of his professional career.

John O. Duey, M.D., Cleveland; Hahnemann Medical College of Philadelphia, 1944; aged 51; died November 12; former member of OSMA; recently associated as counselor at the Brecksville Veterans Administration Hospital.

William Scotte Elliott, M.D., East Palestine; Queens University Faculty of Medicine, Canada, 1930; aged 64; died November 7; member of OSMA and AMA; physician and surgeon in the East Palestine area for 32 years; medical advisor to the local board of health; veteran of World War II.

Frank Charles Harold, M.D., Columbus; Ohio State University College of Medicine, 1952; aged 55; died November 9; member of OSMA, AMA, Industrial Medical Association and American Academy of Occupational Medicine; Commanding General, 2291st U. S. Army Reserve Hospital, with headquarters at Whitehall; former medical director of General Motors Ternstedt Division; former assistant professor of preventive medicine at Ohio State University.

Arvine Wilson Harrold, M.D., Tiffin; Ohio State University College of Medicine, 1934; aged 63; died November 24; member of OSMA and AMA; general practitioner of long standing in Tiffin; physician for the Heidelberg College and General Electric Company; Seneca County coroner; veteran of World War II.

William Gordon Hartnett, M.D., Fostoria; Loyola University Stritch School of Medicine, 1928; aged 68; died October 30; member of OSMA, AMA, American Society of Internal Medicine, and American Thoracic Society; Fellow, American College of Physicians and American College of Chest Physicians; diplomate, American Board of Internal Medicine; practitioner of long standing in Fostoria; veteran of World War II.

Frederick Augustus Heusath, M.D., St. Petersburg, Fla.; Harvard Medical School, 1925; aged 77; died earlier this year; member of OSMA, AMA, International Academy of Pathology, and American Society of Clinical Pathologists; Fellow, American College of Pathologists; diplomate, American Board of Pathology; pathologist for the Lima Memorial Hospital before his retirement.

Ricardo Hernandez Gomez, M.D., Apple Creek; University of Havana, 1940; aged 58; died October 1 as the result of a traffic accident; physician on the staff of Apple Creek State Institute.

Russell Eugene Lightner, M.D., Kingston; Ohio State University College of Medicine, 1915; aged 81; died November 16; member of OSMA; practicing physician in the Ross County community for 57 years; veteran of World War I.

Louis Marx Rosenberg, M.D., Cincinnati; University of Cincinnati College of Medicine, 1947; aged 50; died October 31; member of OSMA, the American Society of Internal Medicine; Fellow American College of Physicians; diplomate, American Board of Internal Medicine; practicing physician in Cincinnati and clinical professor of internal medicine at the University of Cincinnati; served in the Army Medical Corps, 1948-1950.

Art Show Planned
FOR 1972 OSMA ANNUAL MEETING

Space will be provided at the 1972 Annual Meeting of the Ohio State Medical Association, May 9, 10 and 11, at Cincinnati Convention Center for a Physicians' Art Show. The Medi-Art Club of the Academy of Medicine of Cincinnati will merge their annual art exhibit with that of the Ohio State Medical Association at its annual meeting.

Members of OSMA and their wives interested in exhibiting pieces and requiring information regarding this can contact:

Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

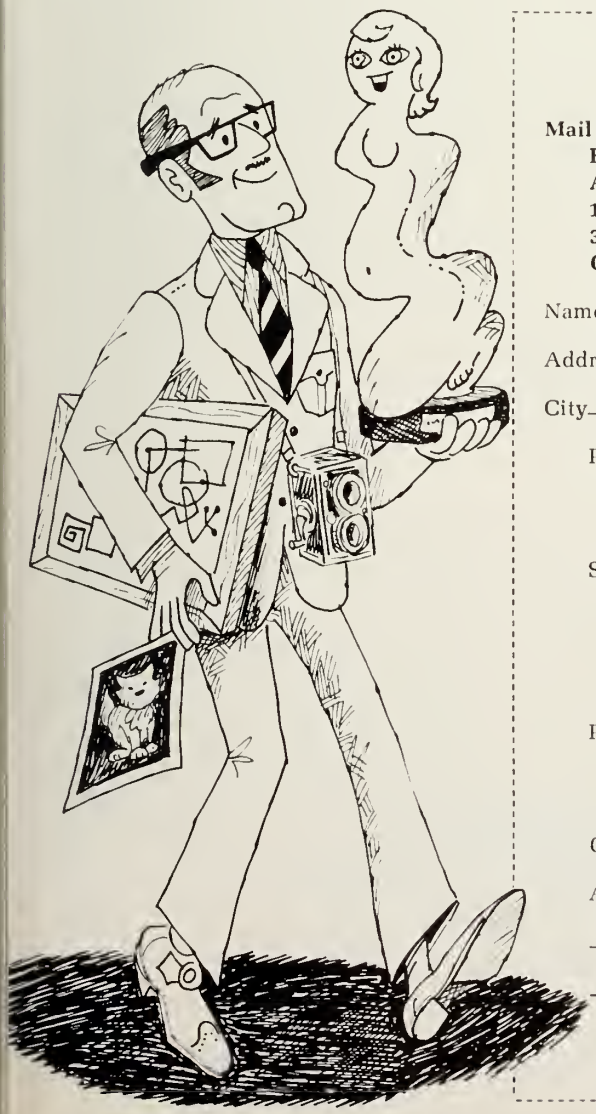
It will be the responsibility of each physician to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expenses involved in entering his or her exhibit.

Exhibitors will be limited to two art pieces per person. Please list in order of preference to be exhibited.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibit to make this an outstanding Art Show.



Application for Space in Art Show Exhibit

Mail to:
Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

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City_____

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(give dimensions)

Sculpture _____

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(give estimated size)

Check one: ☐ Pedestal type ☐ Wall type

Painting _____

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(give dimensions: depth, width and height)

Other information (which you believe will be helpful to the Art Committee) _____

_____

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(Deadline on Art Application to be announced)

Deadline for Submission of Resolutions to OSMA Office is March 9

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1972 Annual Meeting should be guided by the following requirements of the Bylaws:

Resolutions, regardless of whether they have been submitted in advance must be introduced at the first session of the House of Delegates, Monday morning, May 8, at the Cincinnati Exposition Center.

To be eligible for presentation, a resolution must be filed with the Executive Director of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely not later than March 9. This requirement may be waived by a two-thirds majority of the House of Delegates.

Copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 8-11.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 9.

The Part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

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ACTIONS: *Microbiology* Phenoxymethyl penicillin exerts high in vitro activity against staphylococci (except penicillinase-producing strains), streptococci (groups A, C, G, H, L, and M) and pneumococci. Other organisms sensitive to phenoxymethyl penicillin are *Corynebacterium diphtheriae, Bacillus anthracis, Clostridia, Actinomyces bovis, Streptobacillus moniliformis, Listeria monocytogenes,* Leptospira, and *Neisseria gonorrhoeae. Treponema pallidum* is extremely sensitive. *Pharmacology:* Phenoxymethyl penicillin is more resistant to inactivation by gastric acid than penicillin G. It may be given with meals and average blood levels are two to five times higher than the levels following the same dose of oral penicillin G. Once absorbed, phenoxymethyl penicillin is about 80% bound to serum protein. Tissue levels are highest in the kidneys, with lesser amounts in the liver, skin, and intestines and small amounts in all other body tissues and cerebrospinal fluid. Only about 25% of the dose given is absorbed. In neonates, young infants, and individuals with impaired kidney function, excretion is considerably delayed.

INDICATIONS: Phenoxymethyl penicillin is indicated in the treatment of mild to moderately severe infections caused by penicillin G-sensitive microorganisms that are sensitive to the low serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response. Culture and sensitivity testing are especially important in suspected staphylococcal infections because increased resistance has been reported. Phenoxymethyl penicillin is not active against penicillinase-producing bacteria.

Note: Severe pneumonia, empyema, bacteremia, pericarditis, meningitis, and arthritis should not be treated with phenoxymethyl penicillin during the acute stage.

Indicated surgical procedures should be performed.

Medical conditions in which oral penicillin therapy is indicated as prophylaxis: For the prevention of recurrence following rheumatic fever and/or chorea. To prevent bacterial endocarditis in patients with congenital and/or rheumatic heart lesions who are to undergo dental procedures or minor upper respiratory tract surgery or instrumentation.

Note: Oral penicillin should not be used as adjunctive prophylaxis for genitourinary instrumentation or surgery, lower intestinal tract surgery, sigmoidoscopy and childbirth.

CONTRAINDICATION: A previous hypersensitivity reaction to any penicillin.

WARNINGS: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. While more frequent following parenteral therapy, anaphylaxis has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

Some individuals with a history of penicillin hypersensitivity reactions have experienced severe hypersensitivity reactions from a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines and corticosteroids.

PRECAUTIONS: Penicillin should be used with caution in individuals with histories of significant allergies and/or asthma.

The oral route of administration should not be relied on in patients with severe illness, or with nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility.

Occasional patients will not absorb therapeutic amounts of orally administered penicillin.

In streptococcal infections, therapy must be sufficient to eliminate the organism (10 days minimum); otherwise the sequelae of streptococcal disease may occur. Cultures should be taken following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms, including fungi. Should superinfection occur, appropriate measures should be taken.

ADVERSE REACTIONS: While the incidence of reactions to oral penicillins is much less than with parenteral therapy, it should be remembered that all degrees of hypersensitivity, including fatal anaphylaxis, have been reported with oral penicillin.

The most common reactions to oral penicillin are nausea, vomiting, epigastric distress, diarrhea, and black hairy tongue. The hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema, and anaphylaxis. Fever and eosinophilia may frequently be the only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy, and nephropathy are infrequent reactions and are usually associated with high doses of parenteral penicillin.

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Exhibits Wanted

1972 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1972 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Cincinnati Exposition Center, 200 West Fifth Street, Cincinnati. EXHIBIT DAYS will be May 9, 10 and 11.

Mail applications to the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

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Cincinnati Exposition Center, Cincinnati, Ohio, May 8-11

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Deadline For Filing Applications, February 1, 1972

Timely and Important Facts and Figures About OMPAC

It takes money to stage a winning campaign for public office. The Ohio Medical Political Action Committee (OMPAC) helps good candidates get elected. Obviously, therefore, it needs money. Annual membership in OMPAC costs $25. Dues for 1972 are payable now to County Medical Society secretary-treasurers.

★ ★ ★

Experience has demonstrated that the payment and collection of OMPAC dues at the same time medical society dues are payable and collected is the only practical method of securing OMPAC contributions. Most County Medical Societies are cooperating in this combined billing-collecting procedure. Pay OMPAC dues to your local medical society secretary-treasurer. He'll transmit them to the OMPAC office in Columbus.

★ ★ ★

Membership in OMPAC varies year by year. When OMPAC was getting off the ground, the membership was small—525 in 1964 and 245 in 1965. Payments in those years were made by direct mail. That didn't work. In 1966, when the combined billing plan was started at the urging of the Ohio State Medical Association Council, membership reached 2,989. It dropped to 2,794 in 1967 but jumped to 2,889 in 1968. Membership was 2,476 in 1969 and in 1970 it was 2,566. For the year just closed—1971—membership took a serious drop to 2,290, primarily because of disappointing results in several of the state's large counties.

★ ★ ★

OMPAC has paid out approximately $275,000 in support of the candidacies of Ohio candidates for Federal and State public offices. Contributions totaling about $143,000 has been paid by OMPAC to the American Medical Political Action Committee, Chicago, during the period 1964-1970. Of that amount, AMPAC returned approximately $100,000 to OMPAC for use in the support of Ohio candidates. The balance was used by AMPAC to assist medicine-backed candidates for Congress in other states who were faced with a tough campaign battle. In the end, a "correct" vote is important regardless of the home state of the Congressman.

★ ★ ★

Since its start in 1964, OMPAC has made financial contributions to the campaign committees of an aggregate of 232 candiates for Federal and State offiees.

★ ★ ★

OMPAC's record in picking winners has been excellent. Of the 49 candidates for seats in the U.S. Senate and U.S. House of Representatives supported by OMPAC, 42 have been elected—a batting average of 85.7 percent.

Of the 180 candidates for seats in the Ohio Senate and Ohio House who were supported by OMPAC, 155 were winners—a batting average of 86 percent.

In picking winners among candidates for executive offices, OMPAC did not fare so well, winning only one race; losing in two.

★ ★ ★

OMPAC carefully scrutinizes the standing and record of candidates before putting money on the line. Candidates supported by OMPAC, regardless of political party, are selected as worthy of financial support by OMPAC, after (1) Careful analysis of the candidate's record if he has held public office; (2) evaluation of information regarding his character, standing in his community, educational qualifications, and views on social, economic and health-medical issues.

★ ★ ★

OMPAC gets its information on candidates from officials of the state and county medical societies. Also, data and recommendations of individual physicians who know the candidate well are carefully analyzed. Another point taken into consideration is: Does the candidate have a reasonably good chance of winning at the polls?

★ ★ ★

Operating eosts of OMPAC have been amazingly low, the average annual operating eost running between 8 and 9 pereent from receipts from member eontributions. For the eight-year period, 1964-1971, operating eosts have totaled about $40,000.

★ ★ ★

Some candidates in each election do not receive financial help from OMPAC even though they have the active support of the medical profession in their areas. This is because they simply do not need campaign money over and above that obtained from local constituents and from the party coffers. In many instances, such candidates

have little, if any, opposition. There was no contest. OMPAC tries to put its money on candidates really in need of financial assistance. Also, OMPAC always has recommended that each physician, in addition to giving to OMPAC, contribute individually to the candidates and party organization of his choice. OMPAC should be regarded as the ace in the hole.

★ ★ ★

Yes, the wives of physicians may become members of OMPAC. In fact, 25-30 have contributed each year. OMPAC puts no restrictions on its membership. Anyone who believes in the objectives of OMPAC and wants to contribute, may do so.

★ ★ ★

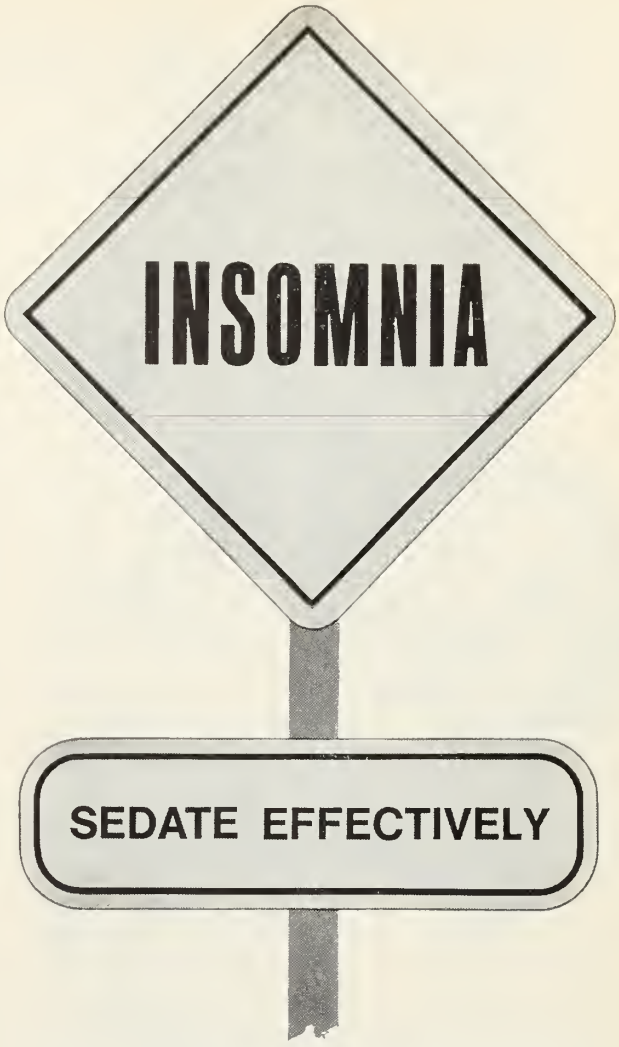
OMPAC does not engage in lobbying in the Congress or in the Ohio General Assembly. It does not formulate policies on public issues. These are the responsibilities of the Ohio State Medical Association and its component county medical societies. Obviously, OMPAC keeps itself informed of the policies laid down by the OSMA.

OMPAC's major objective is to help to determine the make-up of the Congress and the Ohio General Assembly by making financial contributions to the candidacies of those considered by the medical profession of Ohio to be capable, honest, having constructive views on governmental responsibilities and activities, and are supporters of sound social and economic principles.

★ ★ ★

Members of the Board of Directors which administers OMPAC activities are: William J. Lewis, M.D., Dayton, chairman; H. William Porterfield, M.D., Columbus, vice-chairman; Carl A. Lincke, M.D., Carrollton, secretary-treasurer; Frank H. Mayfield, M.D., Cincinnati; James C. McLarnan, M.D., Mt. Vernon; Robert E. Tschantz, M.D., Canton; Paul A. Jones, M.D., Zanesville; A. Burton Payne, M.D., Ironton; Charles L. Blumstein, M.D., Lima; Ray W. Gifford, M.D., Cleveland; Lawrence C. Meredith, Oberlin; and Mrs. M. W. Sloan, Dayton.

Drs. Mayfield, Lincke, Meredith and Tschantz are past presidents of the Ohio State Medical Association. Dr. McLarnan is at present a member of the OSMA Council. Mrs. Sloan is a past president of the Woman's Auxiliary to the OSMA and at present Auxiliary legislative chairman. Dr. Mayfield served as chairman of the committee from 1964 to 1971. He asked to be relieved of the chairmanship for 1972. Dr. Lewis, now chairman, is a member of the Board of Directors of the American Medical Political Action Committee, based in Chicago.



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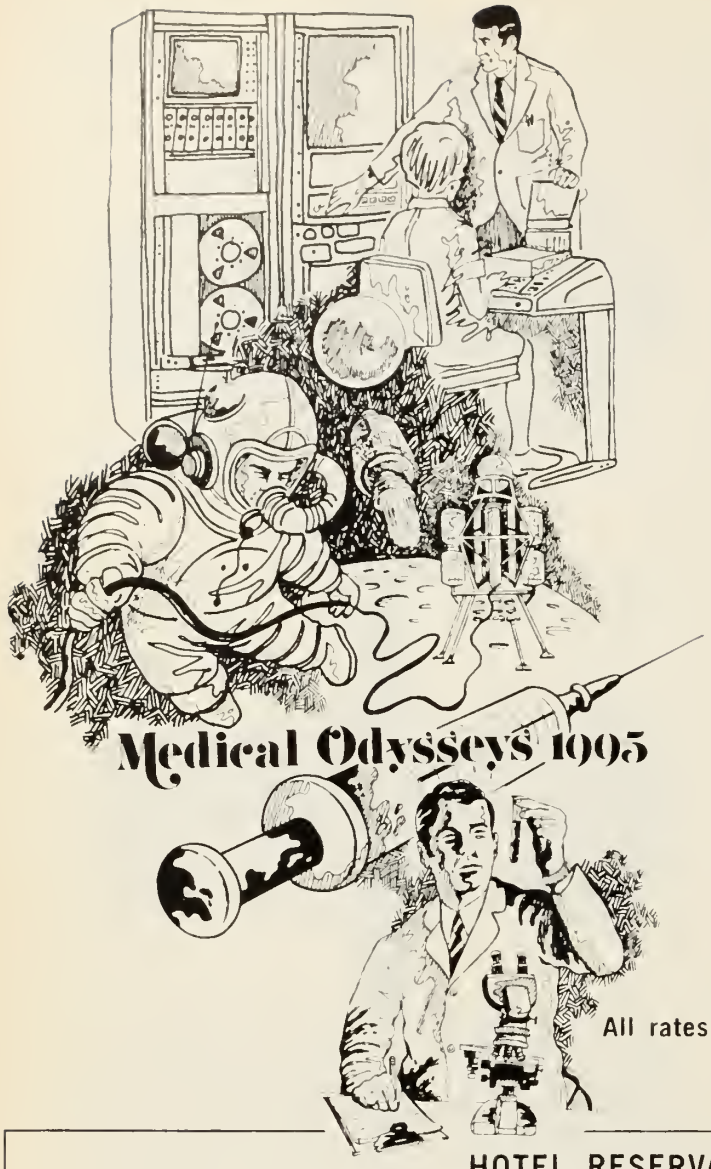
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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

A NEW YEAR — a New Look — a New Resolve — a New Auxiliary Sense. Verily — "Ring out the old, ring in the new". . . . . The old year passes into the mists of time. The new year is young, lusty, full of hope and promise.

This reporter has no wish to use this column as a pulpit and to come forth with any sermon. What she does believe, however, is that this column is an important means of communication and that such communication should, occasionally at least, "jog" the membership (and the doctors!) into renewed awareness and enthusiasm for Auxiliary efforts.

Is there a better time than this to do just that — at the beginning of this New Year of 1972? Remember the time-honored tradition of making New Year Resolutions? We don't hear much about that any more. Perhaps too much fun was poked at them. Yet the making of sensible, pertinent resolutions is not a fun game or something without merit. It is a step in the right direction — that by "resolving" to do thus and so, we are conscious of our shortcomings and are, at least, making an effort to do something about them.

I don't know of anything which perplexes this writer more than to hear a doctor's wife say "I'm in too many organizations already; there's no more time to give Auxiliary work." Certainly there is no quarrel about giving time and effort to other community projects. That's as it should be. But to use those other efforts as an excuse for not meeting their obligations as doctors' wives is something else again. For every doctor's wife, whether she is willing to admit it or not, does have an obligation to the medical profession. Only she should not look upon it as an obligation; rather she should consider it a privilege!

Chrysanthemum Ball

It was "loverly" — almost like a scene out of the movies. There were "soft lights and sweet music," an excellent cuisine, attractive women, distinguished-looking escorts. The annual fund-raising Chrysanthemum Ball of the Cuyahoga County auxiliary is something extra special. I know whereof I write because I was lucky enough to be there as the guest of my charming hosts — Dr. and Mrs. Reuben Gould. The place — Cleveland's Statler Hilton Hotel; the date — Saturday night, November 6.

Greeting the guests were Dr. and Mrs. Paul Chrenka (Jean is Cuyahoga's president). And there were close to 400 such guests to greet! The theme of the Ball this year was the Imperial Standard of the Royal House of Japan — the 16-petaled chrysanthemum. In keeping with that theme, chrysanthemums and Japanese parasols were tastefully banked on the stairs leading to the Windsor Room for the cocktail hour. In the Grand Ballroom where dinner was served, the tables were covered with gold cloths. On each table there were mums of yellow, bronze and white with orange velvet bows to lend a festive, colorful touch. There were gifts of perfume for the women, fountain pens for the men.

At nine o'clock, Hal Lynn and his nine-member orchestra, gaily dressed in brilliant colored

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Hopi coats, gave forth with irresistible music. The bandstand was covered in lacquer red felt and above the band hung a large (6 feet in diameter) yellow chrysanthemum, its petals outlined in red. The pillars on either side of the band had columns of mums from ceiling to floor, again following the original design.

Dr. and Mrs. P. John Robechek (Dr. Robechek is president of OSMA) were the honored guests. Dr. John Gaughan, president of the Cleveland Academy of Medicine, presented Mrs. Chrenka, auxiliary president, with a bouquet of American Beauty roses. And now — the crowning achievement: Close to one thousand dollars was netted for the auxiliary's Philanthropy Fund. "Loverly," did I say in the beginning? It certainly was.

The Ball's success was due to the indefatigable and creative efforts of Mrs. Rupert B. Turnbull, chairman and Mrs. Robert E. Hermann, co-chairman, and their hard-working committee: Mrs. Antonio R. Antunez, Mrs. John Collis, Mrs. Caldwell Esselstyn, Mrs. Vernon D. Hacker, Mrs. Richard J. Hilfer, Mrs. James S. Krieger, Mrs. Leonard L. Lovshin, Mrs. James R. O'Malley, Mrs. J. Kenneth Potter, Mrs. Fred Rittinger, Mrs. Sam I. Sato.

Benefit — Apple Tree

Hamilton County's Holiday Ball on December 4 at the Netherland Hilton's Hall of Mirrors in Cincinnati was another highly successful social occasion for a worthy cause — this time for the benefit of its Apple Tree Day Care Center for the children of hospital personnel. (It was the season to be Merry — and do good at the same time!) Mrs. Manuel Rodarte, Hamilton County publicity chairman, writes me that the local publicity on the dinner dance was so tremendous that reservations doubled this year. The *Cincinnati Enquirer* ran a terrific story on the Day Care facility, along with a large photograph of some of the children at play.

The Auxiliary is the main source of support for the Apple Tree. This year's dance proceeds will be used for the day to day operation of the center. For the first time in five years, the tuition has had to be raised. When the Apple Tree opened its doors seven years ago, 20 children were registered. Now it is licensed to care for 40 children. The facility has been certified by the Board of Health and also has a food service operator's license. The staff consists of three-full time teachers, two assistant teachers and five child development trainees who work with a board of 15 auxiliary members.

But now — back to the festivities at the Netherland Hilton on December 4: There was a cocktail party at 6:30 p.m., followed by an 8 p.m. dinner. Throughout the dinner time, there was an informal modeling of beautiful furs from Gidding-Jenny of Cincinnati. Then came Pete Wagner's Orchestra providing tuneful and lively music for the dancing. Mrs. Richard Neubauer served as chairman of the Holiday Ball. She is also a board member of the Apple Tree and considers working for the center similar to throwing a pebble into water, "with increasingly wider impact."

Important bits of News: the **Hamilton Auxiliary** has received a citation from the County Civil Defense Group for "invaluable services and cooperation in conjunction with Hamilton county in the disaster exercise held at Christ Hospital on October 2, 1971". . . . Mrs. Herman Nimitz, a past county president and past State President, has received an honorary lifetime membership in



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the Hamilton auxiliary. On November 14, the Auxiliary manned a booth for the Diabetic Fair at the Cincinnati Convention Center. Twenty-five auxiliary members assisted at the Fair by registering visitors and directing them to laboratory technicians for free blood sugar tests. Over 5,000 Cincinnatians attended the day long activity. There was a special exhibit of the Apple Tree.

Toledo-Way

Early in November, a Health Careers information rally was held at the Academy of Medicine auditorium. It was sponsored by the **Lucas County** auxiliary, with emphasis on "How to Get Involved in Health Careers Now." Special guest speaker was Mrs. Margaret Moore, director of volunteers, Riverside Hospital.

The Lucas County group has been getting some pretty terrific newspaper coverage, judging from the clippings I'm receiving from Mrs. Frederick C. Bowdle, publicity chairman. The papers and television stations really "covered" the recent annual guest day tea at which Mrs. Woody Hayes spoke. Here are some of the choice bits recorded by the reporters: During football season, Mrs. Hayes said, she never bucks her husband or criticizes him. "I'm so sweet, I hate myself", she commented. But after the season is over, she has what she and her husband call "Anne's bitching week". Her soul is cleansed and she becomes a normal wife once again. . . . . Coach Hayes and his wife admittedly are hard losers. "And why shouldn't we be?" she asked. "I don't see any sense in playing the game if you don't play to win. And you aren't going to win them all", she reminded her audience.

Since branching out on her own as a public speaker, Mrs. Hayes said she has learned to understand her husband. "I used to think Woody was the perfectionist. Now I realize I was the perfectionist. I wanted to put Woody Hayes in a mold," she confessed. "We can't make molds of people, we can't put them in pigeonholes. You can't drive people into what you expect them to be." Anne Hayes spoke with warmth, humor and complete candor. She holds her audience, and she gives them laughter. As Lucas president Mrs. Robert Cooke said in closing the meeting, "A good laugh is what we all need."

The Fourth District meeting was held in November at the Fremont County Club. The social hour was held at 11 a.m., followed by a noon luncheon. Mrs. W. L. Damschroder, fourth district director, presided at the meeting. Guest speaker was James S. Imboden, field representative of the AMA. He addressed the group on current national health legislation.

An effective appeal was sent to all Lucas County members, urging them to "Come Join Us on November 10th" to give blood at the Red Cross and then "join us for lunch at Sonia Andersons." The appeal pointed out that 116 pints of blood were needed and that "with the membership as large as ours, surely we can meet this quota . . . . do help us to help others and have some fun too."

Ottawa County's Doin's

Two state officers were present on November 11 when Mrs. D. W. Felber entertained members of the Ottawa County auxiliary in her home. Attending were Mrs. L. A. Loria, state president-elect, and Mrs. Karl Ulicny, state third vice-president. Mrs. Ulicny talked on AMA-ERF (Susie is state chairman and has done a terrific job in that capacity for three years). It was announced that Mrs. John Bodie and Mrs. C. R. Wood had made the Halloween favors for trays



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of patients at Magruder Hospital. On December 9, the Ottawa group met at the home of Mrs. William Coon for its annual Christmas party and exchange of gifts.

The *Port Clinton Herald* on November 15 ran an outstanding feature-length story on Mrs. Cyrus R. Wood, a talented doctor's wife whose husband is Ottawa County coroner. Wandas Wood has a rather unusual interest — witchcraft, of all things! "This particular interest of mine concerning witches started after I saw my first witch in Dayton, Ohio, in September of 1964 when I was attending a Medical Auxiliary workshop," says Mrs. Wood. "I didn't think too much about it until I started reading newspaper articles about witches coming to this country from England.

Since that time, Mrs. Wood has delved into the subject and speaks before various groups. One point the speaker makes clear: "I do not delve into the rituals of witches . . . . that is not my cup of tea" . . . . For her program, Mrs. Wood quotes extensively from the columns of the late humorist Douglas Welch, from Billy Vaughn's article on witches' convention and from articles by Norton Mockridge. Newspaper and magazine clippings and articles she has collected over the last seven years are also used. In her talks, she prefers to stress the "funny side" of witchcraft. From what I hear there's quite a bit of magic in those talks. . . . .

"Madam President"

Mrs. Russell Wiessinger, state president, deserves a special salute for her outstanding newsletter (to county presidents, presidents-elect and State Board members) this past month. Not only was it chuckful of important reminders and helpful data, but the paragraphs on a "Christmas Recipe" were beautiful, meaningful and well worth remembering every season of the year!

SEVENTEENTH ANNUAL

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AMA Statement on Price Control As It Relates to Physicians' Fees

On December 15 the American Medical Association released the following statement in relation to Phase II of the Federal Wage-Price Control Program as it pertains to physicians' fees.

THE AMERICAN MEDICAL ASSOCIATION SUPPORTS PRESIDENT NIXON'S EFFORTS TO CURB INFLATION AND TO HOLD PRICE RISES TO AN AVERAGE OF 2.5 PERCENT ACROSS THE BOARD.

WHILE WE URGE PHYSICIANS TO ACT IN ACCORDANCE WITH THE REGULATIONS, WE FEEL COMPELLED TO POINT OUT CERTAIN DISCRIMINATORY ASPECTS TO THEM.

THOUGH WE HAVE NOT YET SEEN THE OFFICIAL REGULATORY LANGUAGE, THE GUIDELINES FOR PHYSICIANS' FEES APPEAR TO SINGLE OUT HEALTH CARE PROVIDERS FOR SOME REGULATORY CONTROLS THAT ARE NOT APPLIED TO OTHER PROVIDERS OF SERVICES. IT VIOLATES THE PRINCIPLE OF EQUAL TREATMENT AND FAIR PLAY TO IMPOSE SPECIAL BURDENS ON SMALL SEGMENTS OF THE POPULATION — IN THIS CASE PHYSICIANS, DENTISTS, OSTEOPATHS AND OTHER NONHOSPITAL PROVIDERS OF HEALTH SERVICES.

GENERALLY ALL PROVIDERS OF SERVICES ARE PERMITTED TO PASS THROUGH DOCUMENTED, LEGITIMATE INCREASES IN THE COST OF DOING BUSINESS. EXCEPT FOR VERY LARGE CORPORATIONS, ADVANCE APPROVAL IS NOT REQUIRED.

HOWEVER, THE GUIDELINES AS WE UNDERSTAND THEM PROVIDE NO AVENUES FOR RELIEF FOR PHYSICIANS, OSTEOPATHS, DENTISTS, ETC., WHOSE INCREASED COSTS REQUIRE MORE THAN A 2.5 PERCENT ADJUSTMENT IN FEES. HOPEFULLY, SUCH RELIEF MAY BE AVAILABLE IN THE OFFICIAL REGULATIONS. BUT AT BEST PHYSICANS WHOSE COSTS MAY JUSTIFY INCREASES OVER THE 2.5 PERCENT GUIDELINE WILL HAVE TO APPLY FOR APPROVAL IN ADVANCE, WHILE PROVIDERS OF SERVICES OUTSIDE OF THE HEALTH CARE FIELD ARE SUBJECT TO NO SIMILAR RESTRAINT. WE QUESTION WHY SUCH REQUIREMENTS ARE IMPOSED ON PHYSICIANS, ESPECIALLY WHEN PHYSICIAN INCOME ACCOUNTS FOR ONLY 13 CENTS OF THE HEALTH DOLLAR.

THERE IS THUS EVERY INDICATION THAT ADMINISTRATION OF THE OVER-2.5 PERCENT REGULATION WILL HAVE A DISCRIMINATORY EFFECT. MOST IMPORTANT OF ALL, IT REMAINS TO BE SEEN HOW THIS ASPECT OF THE REGULATIONS WILL AFFECT SERVICES TO PATIENTS. IF APPLIED TOO RIGIDLY, THE REGULATIONS COULD STIFLE INNOVATIVE PRACTICES AND HAMPER THE DEVELOPMENT OF IMPROVED PATIENT CARE. FURTHERMORE, SUCH CONTROLS COULD WORK HARDSHIP ON THE ONE MILLION-PLUS PEOPLE EMPLOYED IN HEALTH CARE, DENYING THEM OPPORTUNITIES FOR MODEST WAGE INCREASES AVAILABLE TO THE REST OF THE WORK FORCE. THIS, TOO, COULD ADVERSELY AFFECT THE LEVEL OF HEALTH SERVICES. MAINTAINING A FEE SCHEDULE AND HAVING IT AVAILABLE IS ONE THING. BUT A POSSIBLE REQUIREMENT FOR HAVING SUCH A SCHEDULE "POSTED" WOULD PROBABLY BE DETRIMENTAL TO THE PERSONAL RELATIONSHIP THAT SHOULD EXIST BETWEEN DOCTOR AND PATIENT. FEE POSTING MAY BE SOMEWHAT ACADEMIC IN ANY EVENT, FOR FEW PATIENTS CHOOSE THEIR PHYSICIAN ON THE BASIS OF FEES. THEY ARE MORE INTERESTED IN HIS SKILLS AND THE QUALITY OF CARE.

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Caution, very close observation, and careful adjustment o dose are necessary when: insulin is withdrawn during the tria period in order to avoid ketosis, acidosis, and coma; thiazid diuretics are administered which may result in aggravation c diabetic state and increased tolbutamide requirement, tempc rary loss of control, or even secondary failure; treating patient with impaired hepatic and/or renal function and debilitated, ma nourished, or semistarved patients in order to avoid severe hypc glycemia which may require corrective therapy over sever days; and treating patients with severe trauma, infection, or su gical procedures where temporary return to insulin or additic of insulin may be necessary. Response to tolbutamide is dimi ished in patients receiving therapy with beta blocking agent

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(tolbutamide, Upjohn)

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phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

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Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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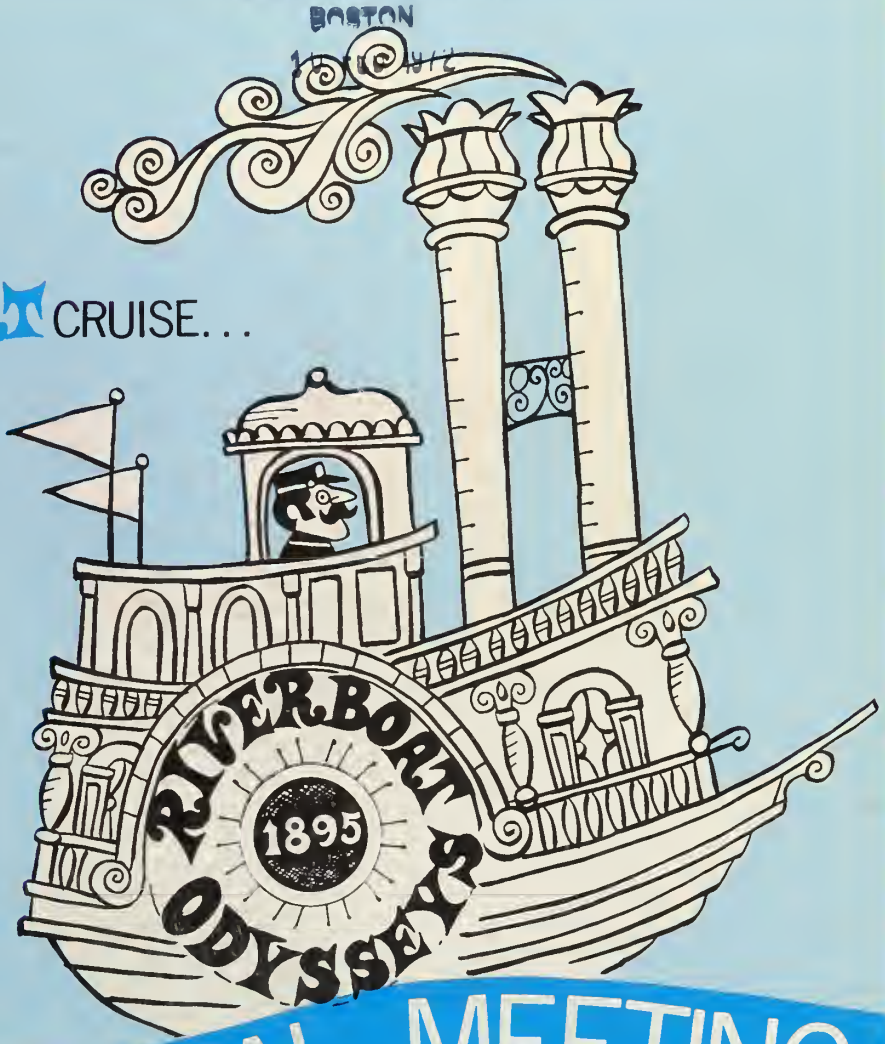
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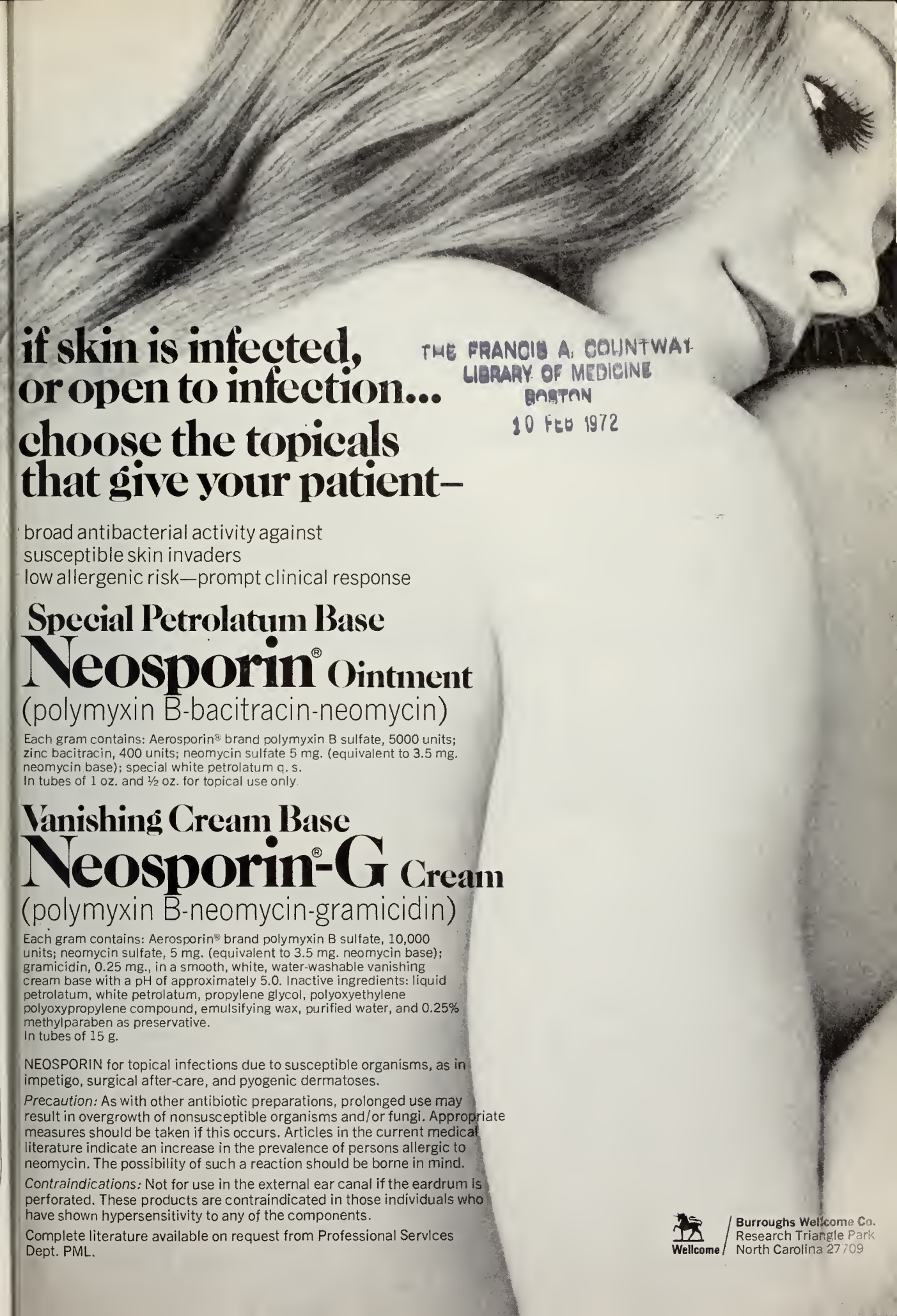
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Complete literature available on request from Professional Services Dept. PML.

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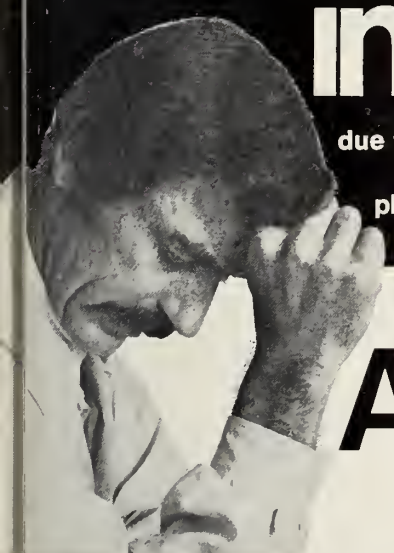
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltosloesterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

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Adverse Reactions: Severe hypoglycemia, though uncommon, ...y occur and may mimic acute neurologic disorders such as ...rebral thrombosis. Certain factors such as hepatic and renal ...ease, malnutrition, advanced age, alcohol ingestion, and ...renal and pituitary insufficiency may predispose to hypogly...mia and certain drugs such as insulin, phenformin, sulfona...des, oxyphenbutazone, salicylates, probenecid, monamine ...idase inhibitors, phenylbutazone, bishydroxycoumarin, and ...enyramidol may prolong or enhance the action of Orinase and ...rease risk of hypoglycemia. Orinase long-term therapy has ...en reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

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Occupational Safety and Health

A Review of What the Occupational Safety and Health Act of 1970 Means to Physicians

By William Lainhart, M.D.
Deputy Associate Director, Cincinnati Office,
National Institute for Occupational Safety and Health

NEW STANDARDS for occupational safety and health are currently being established as a result of the Williams-Steiger Act; The Occupational Safety and Health Act of 1970. Although the Department of Labor is perhaps more responsible than the Department of HEW, especially with regard to enforcement, The National Institute for Occupational Safety and Health, NIOSH, has the responsibility for the research and the establishment of standards in the work place. NIOSH is an arm of the Public Health Service and is a part of the Department of HEW.

Much of the implementation of The Occupational Safety and Health Act is still very much in the formative stage. The Law was passed December 29, 1970, and it is almost a year old, and we are still formulating regulations, ideas, etc. The Department of Labor has set up what they call OSHA, Occupational Safety and Health Administration, headed up by Mr. George Guenther. The director of NIOSH is Dr. Marcus Key. His office is in Washington. We have some 25 or 30 people in Washington, about 250 in Cincinnati and then approximately 35 or 40 in Salt Lake City. Scattered around in regional offices are individuals who are competent within their particular area of occupational health. The State of Ohio is part of our Chicago regional office.

Record Keeping Requirement

There has been an equivalent of NIOSH for a good many years, but only with this Act are we in essence "legitimate." Up until this time we have been primarily operating under the general public health laws which, in essence, embrace any kind of public health including occupational health. Now for the first time, we have legislative authority. We have our own budget and our own staff. We have our own place within the government hierarchy. Previously, we had been doing much of the same kind of activities that we are now expected to do under the Law, but this has been in a less organized fashion. We have provided, for instance, technical assistance to anyone in the United States with regard to occupational health. We have provided consultants for problem areas in various occupational arenas. However, until this Act, there were really no teeth in our actions. Until this time, the only means we had for operating and for getting things done were through such avenues as education, cajoling, pushing, demonstration; these kinds of things. We had no enforcement activities. At the moment we still don't have enforcement activities, but we can work through the Department of Labor, if that becomes necessary, and, I assume, there will be times when this will become necessary. There is a provision in the Act that in the case of imminent danger, we can, in essence, tell the Department of Labor that we think things are pretty bad, and that they should do something about it—post-haste. A case at the moment is an asbestos plant in another state where apparently the levels of asbestos are very high. The levels of asbestosis are inordinately high. I am sure that something has to be, and should be, done.

I hope to cover three basic areas of information for you: 1) How does this Act affect the physician as a private employer? 2) How does this Act affect the industrial physician? 3) Are there any aspects of this Act which pertain to public health? The practicing physician becomes involved because of his role as an employer and as a possible employee. He might employ a nurse or two or may have a full-scale clinical operation. He may not only handle industrial accidents or illnesses, but he may

This article is a transcript of remarks made by Dr. Lainhart on November 17 before the OSMA Committee on Environmental and Public Health, whose structure includes matters of occupational health. The remarks are informal, but can be very helpful to Ohio physicians involved with the new Occupational Safety and Health Act of 1970.

be the physician on retainer to a company or he may be a full-time occupational health physician. Under the Act, the Department of Labor has established a series of reporting mechanisms for the employer, and I'm sure that the physician, not only for his own employees, but also as a representative of an industrial concern, will get involved in this. The Department of Labor has a publication called *Record Keeping Requirements,* and this was sent to each employer. It says "beginning July 1, 1971, you are required by law to keep **new** records of occupational injuries and illnesses." This booklet contains the information and forms needed to maintain these records. In essence, these aren't very complicated, but I'm sure that there are going to be some questions. Such a thing as "what is an occupational illness or injury?" immediately comes to mind. How do you define these things? I'm sure that there are some that are out and out, no question. I am sure that there are some gray areas where we don't know the answer.

Within the record-keeping requirements, there are three forms: there is a log of the individual injuries or illnesses, and then a more complicated form for each of them and then finally a summary report. There are approximately 4½ million establishments in the United States who have an accounting number at the Social Security Administration which means that something like 4½ million establishments report earnings to the Social Security. The guidelines were sent to each of these people with a letter indicating how they were to keep the records. The Bureau of Labor Statistics within the Department of Labor, has made a sample of this universe of 4½ million establishments for reporting requirements.

Within the United States any kind of broad scale information about occupational disease and injury has been woefully lacking. This sample—I think it's somewhere around 70,000 establishments throughout the United States—will be required to mail a report in January for the past six months, and from this we hope to be able to get some sort of statistics for the United States as a whole.

Priorities of Sample

The sample will be heavily weighted for large industry. We have to set priorities on these larger industries. From this sample, we hope to begin to get some notion of the extent of the occupational health problem, where the problem is, what kinds of illnesses are involved, what kinds of work injuries are involved, what kinds of length of times away from work are we talking about, etc.

The National Institute for Occupational Safety and Health has taken a subsample of approximately 10,000 from this Bureau of Labor Statistics sample for Environmental Health Surveillance. Basically, what we're trying to do is to get more detail about what are the hazards in the work place and how many people are exposed. This will, in essence, be a more quantitative description of the problem. This will be a personal interview, "walk through" kind of thing, that will start right after the first of the year. We'll be in nonagricultural establishments to begin with. Perhaps we will go into agricultural areas later.

Basically then, these are the major responsibilities of the physician as an employer. My further remarks concern other parts of the Law that will affect physicians more as a consultant or a full-time employee in industry.

References to Medicine

There are really three major sections in the Act that I think contain references to medical activities. The first one that I'd like to mention is that standards will be set for various work places and for the use of various substances in the work place and it will be the responsibility of the employer to monitor or provide protection to safeguard their health. When these standards are set up, there will be timetables for compliance and/or schedules for medical examinations. We have a sort of counterpart of this in the coal miner where coal workers' pneumoconiosis ("black lung") is a potential problem. There are requirements for the kinds of examination and the periodicity of these examinations and the rights or options that the man has following such examinations.

The second section deals with record keeping and the job of informing the employee. Record keeping has already been discussed for the employer status of a physician. After such examinations and record keeping requirements as are necessary are met, and when hazards are found, the employee will have to be told of the findings, which toxic materials he is being exposed to, the levels of those materials, and if he is being affected, he is to be told that.

The regulations concerning this matter have not yet been promulgated, but we do expect that there will be some medical and biological monitoring. Obviously, the industrial physician will be involved in conducting these tests and then talking with the individual employees regarding the consequences of their exposure. We are already doing this in such studies as our asbestos study. Here we are requesting of the man that we in NIOSH be allowed to notify not only his private physician, but also his occupational health physician, if that plant has a physician. Obviously, if the man has changes in his lungs, (x-rays or pulmonary function changes), he may or may not know about

these. It certainly seems to us that it is the physician's role to interpret these results to him and to give him advice as to what future course of action he should follow.

Private Physician's Report

If the patient is being seen by his private physician and some occupational illness is discovered, it is the responsibility of that physician to make proper records under this Act and to inform the patient and to make proper consultation with the industrial physician if there is one. The industrial physician involved is in a better position to interpret the results to the man and give him advice as to what to do: does he change jobs, does he leave that job, or can he go on in that job, etc.

Now, there is still one other part of the Act which pertains to physicians. This is one where plans are not complete, and we don't know what the future outcome will be, but basically, this portion provides that regulations be promulgated with regard to particular materials where HEW or NIOSH determines that medical examinations must be made to develop what we call a "criteria package." This means that we don't know, at the moment, the total or, perhaps, subtile effects of a particular material or stress and so we are authorized to conduct a study through the industrial concerns involved. If, for example, we are looking at "X" chemical, and we suspect that this has a definite causal effect, and that this effect is determined to be an industrial disease, then we can pay the physician, or the employer really, for the time and equipment necessary to measure those effects. We could, for example, pay for the x-rays in case of potential pneumoconiosis. We could pay for pulmonary function tests in the case of industrial pulmonary disease. We could pay for blood tests, if these were deemed necessary, for example, to get information regarding hypersensitivity to particular materials. We could pay for dermatological examinations if this were necessary.

All these things we can underwrite in order to determine the facts upon which criteria for the development of a standard are based. Basically, what we are trying to do in NIOSH, is to determine that a level of exposure to a material or stress for an eight hour day for a man's working lifetime, is not injurious to his health. There are many ramifications to such a charge, so obviously we have to get as much information as we can from many sources, integrate this information, and try to get together a package where we can say to the employer utilizing "X" chemical or "X" material that "in our best judgment, based on these sets of criteria, the standards should be" so and so. This data goes into what we call a "criteria package," which will provide the basis for better judgment with regard to what are the levels that men and women can be exposed to with regard to a particular material or chemical with no health effects. Included in the documentation of toxicity and measures for preventing human reactions to industrial stresses will be the physician in the industrial setting.

Reaching Into the Home

One other area to touch upon is the public aspects of the Law. First of all, more and more people are working, and therefore, although we are talking about general public health in a limited age span, we can even include maternal and child health. There are obviously going to be questions about how long can a woman work during her pregnancy and what kind of work could she do while pregnant. What materials can she and should she be exposed to at what level during her pregnancy will have to be considered. The Act specifically refers to mental health in an occupational setting. There have been a very few people in the United States who have been interested in occupational mental health or occupational psychiatry, but we have set up a special branch to look into the behavioral and motivational factors of work. We're faced not only with the stresses in the work place, but obviously how they effect the home environment and vice versa. Cases have been chronicled where a man may have had a fight with his wife, and then comes to work and gets involved in an industrial accident. Is this a real occupational problem or isn't it? We must look at the kinds of pressures and stresses that the man brings from home.

The specifics of the Law cannot be delineated here. The general aspects of the Law have been considered as they relate to the practitioner of medicine, in general, and to the industrial physician, in particular. For further information, NIOSH may be contacted through our Regional office. Mr. Marshall E. LaNier (Room 712, New P.O. Building, 433 West Van Buren St., Chicago, Illinois, 60607, 312-353-5471) is the Occupational Health Representative for the State of Ohio.

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Staphylococcus epidermidis	17917	●●●	●	●
Staphylococcus sp.	13565	●●●	●	●●
Mycobacterium smegmatis	19420	●●●	●●	●●
Listeria monocytogenes	13932	●●●	●●	●●●
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Alcaligenes tolerans	19359	●●●	●●	●●●
Neisseria gonorrhoeae	19424	●●	●	●
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Proteus vulgaris	8427	●●●	●	○
Escherichia coli	10536	●	○	○
Escherichia coli	11229	●	○	○
Escherichia coli	11698	●	○	○
Klebsiella pneumoniae	12833	●	○	○
Salmonella typhi	9993	●	○	○
Salmonella typhi	6539	●	○	○
Salmonella typhimurium	13311	●	○	○
Herellea sp.	11959	●	○	○
Pseudomonas aeruginosa	10145	○	○	○
Pseudomonas aeruginosa	7700	○	○	○
Pseudomonas aeruginosa	9027	○	○	○
Pseudomonas aeruginosa	14210	○	○	○
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Medical Advances Institute

To keep the membership informed of activities of the Ohio State Medical Association the following information is published about Medical Advances Institute.

MEDICAL ADVANCES INSTITUTE (MAI) is a not-for-profit corporation organized under the statutes of the State of Ohio. The formation and sponsorship of MAI was approved by the Council of the Ohio State Medical Association on July 18-19, 1970.

The purposes of MAI are as follows:

"To promote the social and general welfare, including training, education and research in the fields of medicine and personal and public health care and development of health care systems; to that end to take and hold, by bequest, devise, gift, purchase or otherwise, any property, real, personal or mixed, tangible or intangible; to sell, convey and dispose of any such property and to invest and reinvest the principal thereof and to deal with and expend the income therefrom for any of the aforementioned purposes; to receive, take title to, hold and use the proceeds and income of stocks, bonds, obligations or other securities of any corporation or corporations, domestic or foreign, for the foregoing purposes, or any of them; to own, construct, manage and lease, as lessor or lessee, any and all types of buildings and structures and to borrow money and issue notes and other evidences of indebtedness and secure any of its obligations by mortgage, pledge or other lien upon all or any of its property for any of the foregoing purposes; and in general to exercise any, all and every power for which a non-profit corporation, organized under the provision of the Ohio Non-Profit Corporation Law to promote the public welfare, can be authorized to exercise."

The membership of MAI is the members of the OSMA Council as it is from time to time constituted.

A Board of Trustees has been appointed to administer the activities and programs of MAI. This board is composed of licensed practicing physicians, representatives of the Blue plans, insurance organizations, hospitals, state health department, consumers and management.

The initial activity of the Board of Trustees was the establishment of a **Professional Standards Review Council** for the purpose of developing parameters of care by established professional standards that will effectuate a professional appraisal of the quality, quantity and cost of all health services. The PSRO Council is composed solely of licensed, practicing physicians. This group is presently developing policy guidelines, methods and the organization to evaluate the quality, quantity and cost of medical care being delivered in Ohio.

A statewide foundation concerned with the delivery of medical services is another program that has been assigned to MAI. On October 2, 1971, the OSMA Council approved the recommendation of the OSMA Ad Hoc Committee on the Study of Health Care Delivery Systems that a Statewide Medical Care Foundation be developed, that it be structured as a separate entity in the organization of the MAI. This Ad Hoc Committee is presently developing a "prototype" statewide foundation with recommendations for structuring within MAI.

It should be noted that a foundation for medical care is concerned with the delivery of medical care while the PSRO Council will be concerned with the development of professional guidelines for which the quality, quantity and cost of the service can be evaluated.

Future programs and activities of MAI will include education and research projects and possibly scholarships, as funds may become available. MAI will conduct programs and studies in many areas, including projects to demonstrate the outstanding effectiveness of the present system of medical care. MAI offers medicine the opportunity to investigate and to publicize its own findings, and to challenge, when necessary, other findings, which are false and misleading.

There has been criticism that little publicity has been given to MAI. It is a fact that numerous presentations have been given at medical society and hospital staff meetings. References to MAI and its mission have been made in the *Ohio State Medical Journal* and in newsletters of the Association. Requests for information about MAI,

(Continued on Page 102)







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The conversion has been initially demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid®
(sodium levothyroxine)

TH FACTS ARE LEAR AND HERE S UR OFFER.

ACTS:
nthetic thyroid drugs are an provement over animal gland ducts. Patients, even athyrotic nes can be completely ained on SYNTHROID (T_4) one Thyroid function tests are sy interpret since they are *edictably* elevated when the tient adheres to SYNTHROID. all synthetic thyroid drugs, NTHROID is the most onomical to the patient.

A

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name _____

Address _____

City _____ State _____ Zip _____

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.



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Morton Grove, Illinois 60053

both oral and written, have been answered promptly. The OSMA Council prepared a resolution on PSRO and MAI for introduction at the May, 1971 session of the House of Delegates. Because of the deadline for the introduction of resolutions at the Annual Meeting, the resolution was introduced as an emergency measure. The House of Delegates did not consider the resolution of an emergency nature. This prevented a thorough discussion at the 1971 meeting of the House.

Questions and Answers About MAI

Question: Will Medical Advances Institute conduct peer review on individual cases?

Answer: Actual peer review will be conducted on a local basis. It is anticipated that MAI will assist county medical societies by coordinating the efforts of the local societies and by providing guidelines and parameters, as well as help in implementing peer review activities.

Q. Why have a separate organization? Why not let OSMA be the coordinating agency for peer review?

A. Because Congressional leadership has already decided that medical societies, themselves, will not be permitted to assume this role. However, they advise that they will permit an organization such as MAI, having input from the public, to assume the responsibility.

Q. Who will conduct peer review in Ohio if Medical Advances Institute is not available to accept this assignment?

A. Congressional leadership has advised that it will be conducted by the Department of Health, Education, and Welfare. Most pending Federal legislation grants full review responsibilities to the Secretary of Health, Education, and Welfare.

Q. Why is it essential that Medical Advances Institute be the statewide contractor for peer review and responsible for its implementation?

A. Otherwise, the Department of Health, Education, and Welfare will impose bureaucratically oriented mandates on county medical societies and hospital staffs on a piecemeal basis and can strangle the small groups, one by one, with no opportunity for organized resistance.

Q. Are there comparable agencies being established by other state medical associations?

A. Most state medical associations are acting in a similar manner in order to protect their members. The principle of the organization being established are similar, but names or the organizational instrument and techniques will vary in detail from state to state.

Q. Is it anticipated that Medical Advances Institute will be involved in other activities besides professional standards review?

A. Yes. Ultimately, the Institute will be used to conduct medical education, medical research, scholarships, and for providing help to areas of doctor shortage, etc.

Q. How does a medical foundation differ from a professional standards review organization?

A. A medical foundation concerns itself primarily with techniques for the delivery of health care and the transmission of funds from the consumer or the consumer's third party payer to the provider. A professional standards review organization assists in the establishment of locally based committees to review quality, quantity and cost of care in behalf of both the provider and the consumer, so that an equitable and fair judgment may be achieved.

Q. Does medicine have a choice as to whether professional standards review will or will not be implemented?

A. No. Public demand and Congressional opinion are of such nature, and medicine is such a minority in this country, that review requirements are upon us. It is the obligation of organized medicine to have such input into the final nature of the legislation that the implementation of review will have sufficient physician input that medical practice will not be destroyed by government bureaucrats.

The girth control pill



Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was on isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libida, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets. One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.), TEPANIL One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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Painful night leg cramps...



unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

- ☐ Prevents painful night leg cramps
- ☐ Permits restful sleep
- ☐ Provides simple convenient dosage — usually just one tablet at bedtime

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** Quinomm is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Trademark: Quinomm

Quinamm

(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps.

Ohio Medical Assistants' Publication Awarded



Ohio Medical Assistants Dorothy Koester and Anna Mae Albert, of Toledo, and Camilla McCuiston, of Dayton, proudly display the publication award presented to the Lucas County Chapter at the American Association of Medical Assistants' 15th annual convention held recently in Atlanta, Georgia. *The Mast*, official publication of the Lucas County Chapter, AAMA, placed third in the chapter publication contest. Mrs. McCuiston is president of the AAMA Ohio State Society.

American Physicians Art Association Invites Members

Officers of the American Physicians Art Association would like to invite medical colleagues to become members of the national nonprofit organization which is dedicated to furthering art interests of the medical profession.

An art exhibit is held annually in conjunction with the annual meeting of the American Medical Association. The APAA has a membership which extends across the entire United States, Canada and Latin America. Every state in the Union is represented through a regional director. It is the hope of the APAA to establish a central photographic archive of its members' art works, to be used for year-round press and magazine publicity in the physicians' home towns as well as nationally.

The organization is totally supported by the members and friends of the APAA. The types of memberships are: life sponsor membership, $200; sponsor membership, $30; regular membership, $15; associate membership, $5. (Associate membership is for medical students, interns, and residents.)

If you are interested in becoming a member, or if you wish further information, please contact the President of APAA, A. M. Gottlieb, M.D., 3801 Miranda Avenue, Palo Alto, California 94304.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo-

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

ligh cure rate:* 96% of 571 males, 95% of 294 females
)osages, sites of infection, and criteria for diagnosis and cure are defined below.)**

ıssurance of a single-dose, physician-controlled treatment schedule

lo allergic reactions occurred in patients with an alleged history of penicillin sensitivity 'hen treated with Trobicin, although penicillin antibody studies were not performed

ıctive against most strains of Neisseria gonorrhoeae <u>in vitro</u> (M.I.C. 7.5-20 mcg/ml)

. single two-gram injection produces peak serum concentrations averaging about 00 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

lote: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the ymptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ffective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for onorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should e instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found ypersensitive to it.

*ata compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-artin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-eatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the llow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined at reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or ilures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

obin; hematocrit and creatinine clearance; elevation of alka-e phosphatase, BUN and SGPT. In single and multiple-dose s dies in normal volunteers, a reduction in urine output was ted. Extensive renal function studies demonstrated no con-stent changes indicative of renal toxicity.

)sage and administration: Keep at 25°C and use within 2 hours after reconstitution with diluent.
ale—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

)w supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Health Department Memo on Outbreaks of Measles

Following is the text of a memorandum sent to *The Journal* by an official of the Ohio Department of Health.

Recently reported outbreaks of measles in various parts of the country have led to concern about the potential for similar outbreaks in Ohio. The following information may be of value to your members, and we would appreciate you passing it along to them.

During 1970 there was a major increase in measles incidence in Ohio. Incidence rates rose from 6.2 per 100,000 population in 1969 to 38.4 per 100,000 in 1970. Rates similar to the 1970 rates are expected in 1971 due largely to major outbreaks occurring in the 1970-71 epidemic season. Since these outbreaks were localized to a few major cities, we anticipate similar outbreaks in the 1971-72 epidemic season.

Outbreaks can be prevented if a sufficient number of susceptibles are vaccinated before exposure. Repeated experience with attenuated live measles vaccine (both Schwartz and further attenuated Edmonston strains) have shown an efficacy of 90-95 percent with long-term protection. The original Edmonston strain vaccines which were given in conjunction with immune serum globulin were not as effective. Vaccination is not as effective when given at less than one year of age.

We would urge immediate vaccination of all susceptible children, particularly in the 1-5 year age group. Children vaccinated with a combination of a vaccine and immune serum globulin in the past and those vaccinated at less than one year of age should be revaccinated.

Measles vaccine is available to private practitioners free of charge from the Ohio Department of Health. The Department also offers the combined Rubella/Measles vaccine. Requests for vaccine should be made to the local health department.

If outbreaks of measles do occur, the Ohio Department of Health has vaccine and personnel available for epidemic control through intensive community immunization programs. The success of such programs will depend on early reporting of measles cases.

Your cooperation in early reporting by telephone to your local health department can result in stopping an outbreak and preventing a great deal of measles suffering and death in your community.

Any questions regarding the Immunization Program may be addressed to:

John H. Ackerman, M.D.
Chief, Bureau of Preventive Medicine
Ohio Department of Health
450 East Town Street, P.O. Box 118
Columbus, Ohio 43216
Telephone Number: 614-469-4643

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MDs in the News

William S. Kiser, M.D., has been named executive secretary of the Cleveland Clinic Foundation. Dr. Kiser joined the clinic's staff in 1964 and has been head of the Department of Urology's Section on Renal Preservation and a member of the kidney transplant team. He also served as the scientific director of the clinical research program. In addition to his new duties, he plans to continue an active patient practice.

Dr. John N. Meagher, Columbus, was installed as president of the Congress of Neurological Surgeons at the organization's fall meeting in Florida. Dr. Meagher was 1971 president of the Academy of Medicine of Columbus and Franklin County.

Dr. Ian I. Irons, of Bellevue, was named chairman of the Board of Directors of the Society for Computer Medicine at the organization's first national conference in Chicago. He also was a speaker during conference program.

Dr. Ernest W. Johnson, Columbus, was elected an at-large member of the Board of Governors of the American Academy of Physical Medicine and Rehabilitation at the organization's 33rd annual assembly in San Juan, Puerto Rico. Dr. Johnson is professor and chairman of the Department of Physical Medicine at Ohio State University.

The American Fertility Society has announced its fifth postgraduate course and 28th annual meeting to be held at the Waldorf-Astoria Hotel in New York City February 27, and the annual scientific meeting for February 28-March 1. Further information may be obtained from Herbert H. Thomas, M.D., Medical Director, The American Fertility Society, 1801 Ninth Avenue South, Suite 101, Birmingham, Alabama 25205.

ALSO AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS BUCCAL Tabs

Methyltestosterone N.F.-5 mg.

Android® 10

Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION. Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN

THE BROWN PHARMACEUTICAL CO., INC.
2500 West 6th Street, Los Angeles, California 90057

Continuing Education Opportunities for Physicians in Ohio

February

Medical Pearls — Akron City Hospital 525 E. Market Street, February 16, 8:30 a.m.; Marvin J. Sakol, M.D., coordinator.

Internal Medicine — Ohio State University College of Medicine, February 16.

ENT — Ohio State University College of Medicine, February 17.

Headaches — When Are They Serious? — St. Elizabeth Hospital, Youngstown, February 18; Dr. R. Gilliland.

Diagnostic Laboratory Seminar—Ohio Academy of Family Physicians, and Consolidated Biomedical Laboratories, Inc., at Imperial House, North, Columbus, February 19-20.

Treatment in Psychiatry—Theory and Practice — Veterans Administration Hospital, Brecksville, February 21-25.

Learning Disabilities and the Physician — Cleveland Clinic Educational Foundation, February 23.

Advances in Orthopaedic Surgery — Cleveland Clinic Educational Foundation, February 23-24.

Fourth Annual Infectious Diseases Seminar — Sponsored by CONMED in cooperation with the University of Cincinnati College of Medicine, at Shriners Burns Institute, Cincinnati, February 24.

Respiratory Disease in Children — St. Elizabeth Hospital, Youngstown, February 25; Dr. K. Wegner.

Ophthalmology — Ohio State University College of Medicine, February 28-29.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Surgical Treatment of Coronary Artery Disease — Youngstown Hospital Association, South Branch, February 28, 4 p.m.; Drs. J. J. Turner and M. P. Bhatti.

March

Allergy—When to Test. Is Drug Therapy Helpful in the Long Term?—St. Elizabeth Hospital, Youngstown, 8-9 a.m. March 3.

Fifth Intercontinental Conference on Diagnostic Medicine — Hawaii, March 4-18; for details contact Ohio Academy of Family Physicians, 4075 N. High Street, Columbus 43214.

Pediatric Clinic Day—Columbus, March 8; contact Ohio State University, Center for Continuing Medical Education, 410 W. 10th Street, Columbus 43210.

Renal Hypertension Clinic—by RMP Unit of Pittsburgh at St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 10.

General Practice Seminar — Ohio State University College of Medicine, March 11-12 at the Center of Tomorrow, 24 Olentangy River Road, Columbus.

A & B Blockers and A & B Stimulators (Pharmacology Series) — Youngstown Hospital Association, March 13.

Educational Opportunities in Ohio — *Continued*

Orthopaedic Rehabilitation—At the Hollenden House, Cleveland, March 13-15; sponsored by the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Illinois 60611.

Maxillofacial Trauma — Workshop sponsored by the American Academy of Facial Plastic and Reconstructive Surgery and the University of Cincinnati Medical Center; March 13-16; contact Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati 45219.

Diagnosis and Management of Hypoglycemia —Trumbull Memorial Hospital, Warren; noon program, March 14; to be presented by James Craig, M.D., and or Bernard Landau, M.D., of Case Western Reserve University.

Infectious Diseases—OSU College of Medicine, March 14; contact Center for Continuing Medical Education at the College.

Some Aspects of Diuretic Management—Fort Steuben Academy of Medicine, March 14, at 8:15 p.m., Fort Steuben Motor Hotel, Steubenville; guest speaker, E. Gordon Margolin, M.D., well-known Cincinnati specialist in internal medicine, renal diseases, and electrolytes.

Detection of Australian Antigen—Cleveland Clinic Educational Foundation, March 15-16; co-sponsored by the American Society of Clinical Pathologists.

Seventh Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 15-16; Marvin J. Sakol, M.D., coordinator.

Advances in Urology—Cleveland Clinic Educational Foundation, March 15-16.

Veterans Administration Hospital Annual Seminar—VA Hospital, Cincinnati, March 16; Gene Conway, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

G. I. Bleeding—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 17.

Diagnosis and Repair of Facial Fractures — Medical Center, University of Cincinnati, March 20-24; Donald A. Shumrick, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

A Lipid Tutorial—Cleveland Clinic Educational Foundation, March 23-24.

Practical Laboratory Chemistry, Manual and Automated —Cleveland Clinic Educational Foundation, March 23-24.

Examination of the Newborn; Cardinal Points of the Examination — St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 24.

Huntington Chorea Association—OSU College of Medicine, Columbus, March 26-29; contact Center for Continuing Medical Education, at the University.

Isotopes in Clinical Medicine (Pharmacology Series) — Youngstown Hospital Association, March 27.

ENT Emergencies—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 31.

April

Cancer Symposium — Ohio State University College of Medicine, April 5.

Diagnostic Immunology — Cleveland Clinic Educational Foundation, April 5-6.

Immunization Program Preview—St. Elizabeth Hospital, Youngstown, April 7, 8:00 to 9:00 a.m.; Dr. B. Brucoli.

Chemotherapy in the Patient with Incurable Cancer—Youngstown Hospital Association, South Unit, April 10, 4:00 p.m.; Drs. W. D. Loeser and H. Hoffler.

Hyperthyroidism—Trumbull Memorial Hospital, Warren, April 11, 12:00 noon to 1:00 p.m.; speaker, Dr. Richard P. Levy, Case Western Reserve University.

Annual Trauma Meeting — Fort Steuben Academy of Medicine, Fort Steuben Motor Hotel, Steubenville, April 11, 8:15 p.m. Subject, **Total Hip Reconstruction,** with guest speaker Dr. Charles M. Evarts, Cleveland.

Internal Medicine (Visiting Professor Program) — Akron City Hospital, 525 East Market Street, Akron, April 13-14; Dr. William Keith C. Morgan, West Virginia University School of Medicine.

Term Management of Acute Respiratory Failure — Cosponsored by the American College of Chest Physicians and the Cleveland Clinic, at the clinic; April 13-15.

What the GP Should Know About Anesthesia — St. Elizabeth Hospital, Youngstown; April 14, 8:00-9:00 a.m.; Dr. R. Richards.

Educational Opportunities in Ohio — *Continued*

Lederle Symposium on "Being a Physician in Our Time" — Ohio Academy of Family Physicians and Ohio State University College of Medicine, at the Sheraton-Columbus Motor Hotel, downtown Columbus. April 16.

A Day of Therapeutics — Akron City Hospital, 525 East Market Street, Akron; American Society for Clinical Pharmacology and Therapeutics. April 19.

Advances in Orthopaedic Surgery — Cleveland Clinic Educational Foundation, April 19-20.

The Hospital-Wide Coronary Care System — Sponsored by the American College of Cardiology, at Good Samaritan Hospital, Dayton, April 19-20.

Estrogens and Their Abuses — St. Elizabeth Hospital, Youngstown, April 21, 8:00-9:00 a.m.; Dr. L. Alexander.

New Antibiotics — Youngstown Hospital Association, South Unit; April 24; 4:00 p.m.; Drs. G. A. Butcher and S. A. Khuddus.

New Concepts and Practices in Diseases of the Colon and Rectum — Cleveland Clinic Educational Foundation, April 26-27.

The Low Back Problem; Proper Examination Explained — St. Elizabeth Hospital, Youngstown; April 28, 8:00-9:00 a.m.; Dr. J. J. Sofranec.

Introductory Course in Nuclear Medicine for Physicians — Dates on request to Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

May

Arteriosclerosis and the Anesthesiologist — Cleveland Clinic Educational Foundation. May 3-4.

Recent Advances in Abdominal Surgery — At Shriners Burns Institute, Cincinnati, May 3-4; Dr. William A. Altemeier, director; contact Office of CONMED, Eden and Bethesda Avenues, Cincinnati 45219.

Most Common Endocrine Disturbances, Exclusive of Diabetes and Thyroid Disease — St. Elizabeth Hospital, Youngstown; May 5, 8:00-9:00 a.m.; Dr. D. Corredor.

Current Virus Infections on the Youngstown Scene — Youngstown Hospital Association, South Unit, May 8, 4:00 p.m.; Drs. R. Tamburro and N. A. Jaffer.

Ectopic Hormone-Producing Tumor Syndromes — Trumbull Memorial Hospital, Warren, May 9, 12:00 noon to 1:00 p.m.; speaker, Dr. Jerome Kowal, Case Western Reserve University School of Medicine.

Renal Hypertension Clinic — RMP, University of Pittsburgh — St. Elizabeth Hospital, Youngstown; May 12, 8:00-9:00 a.m.

Family Relations Workshop — Ohio Academy of Family Physicians Continuing Education in Psychiatry project, Toledo Holiday Inn, May 12-14.

Learning Disabilities in Children — Annual Meeting of the Ohio Chapter, American Academy of Pediatrics, May 13-14 at Atwood Lake Lodge. Contact Charles Q. McClelland, M.D., Chairman, 2101 Adelbert Road, Cleveland 44106.

Flexible Viewing and Photography of the Stomach and Duodenum — Youngstown Hospital Association, South Unit, May 15, 4:00 p.m.; Drs. D. B. Brown and S. S. Guleria.

Anorectal Problems for the Generalist — St. Elizabeth Hospital, Youngstown; May 19; 8:00-9:00 a.m.; Dr. J. Herald.

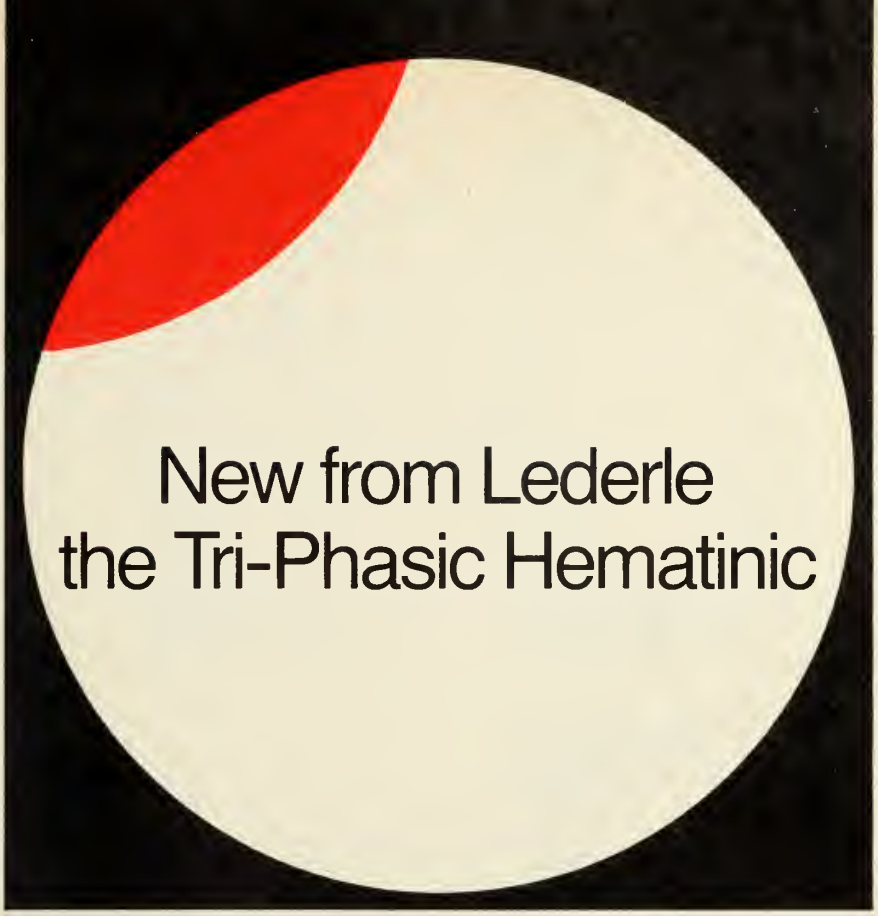
Cytochemistry Applied to Hematology — Cosponsored by the American Society of Clinical Pathologists and the Cleveland Clinic Educational Foundation, at the clinic; May 19-20.

Management of Coronary Occlusion — St. Elizabeth Hospital, Youngstown; May 26, 8:00-9:00 a.m.; Dr. A. Whittaker.

Hepatitis — Subacute Hepatitis, Chronic Active Hepatitis, Needle Hepatitis — Youngstown Hospital Association, South Unit, May 29; Drs. G. A. Butcher and R. S. Arnott.

Fourteenth Annual Refresher Course in Diagnostic Roentgenology — Department of Radiology, University of Cincinnati College of Medicine; Dr. Benjamin Felson, director; May 30-June 3; includes nuclear medicine, radiation physics and radiation therapy; contact Dr. Harold B. Spitz, Department of Radiology, Cincinnati General Hospital, Cincinnati 45229.

(Continued on Page 120)



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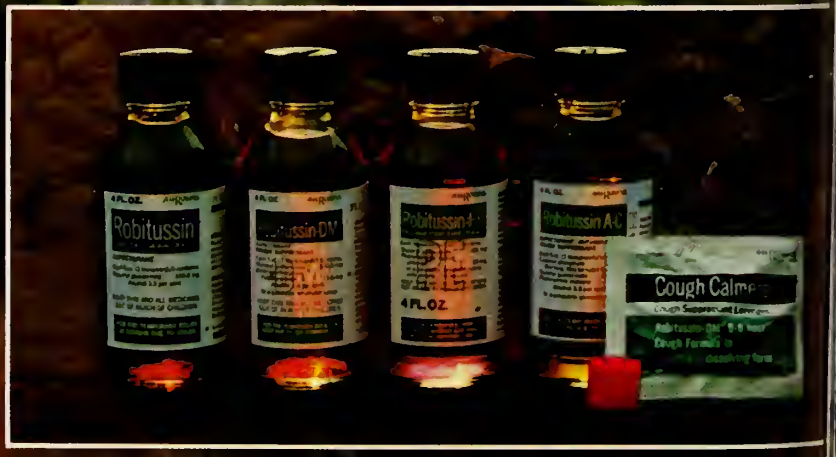
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Educational Opportunities in Ohio — *Continued*

June

Stroke and Rehabilitation — St. Elizabeth Hospital, Youngstown; June 2, 8:00-9:00 a.m.; Drs. R. Gilliland and A. Riberi.

Granulomatous and Nongranulomatous Colitis — Youngstown Hospital Association, South Unit, June 5; Drs. D. B. Brown and Y. P. Sheth.

Symposium on Microneurosurgery — Departments of Neurosurgery, Good Samaritan and Christ Hospitals, Cincinnati, June 8-10; distinguished guest and local faculty; Contact Dr. John M. Tew, Jr., 506 Oak Street, Cincinnati 45219.

Anxiety Reactions and Their Management — St. Elizabeth Hospital, Youngstown; June 9, 8:00-9:00 a.m.; Dr. F. Gelbman.

Cardiology Course — American College of Physicians — At the Shriners Burns Institute, Cincinnati, June 12-16; Drs. Noble O. Fowler and Robert J. Adolph, directors; Contact Office of CONMED, Eden and Bethesda Avenues, Cincinnati 45219.

Management of Hypertension — St. Elizabeth Hospital, Youngstown; June 16, 8:00-9:00 a.m.; Dr. W. Bunn.

Drug Induced Thrombocytopenia and Hemolytic Anemia — Youngstown Hospital Association, South Unit, June 19; Drs. L. M. Pass and N. A. Pappas.

Worms and Man — St. Elizabeth Hospital, Youngstown, June 23, 8:00-9:00 a.m.; Drs. G. Canatsey and P. Van Zandt.

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Clinical & Scientific Features







VOLUME 68 FEBRUARY 1972 NUMBER 2

The Changing State Institutions for the Mentally Retarded

LESLIE Y. CH'ENG, M.D.

HISTORICALLY the first recorded intensive study and treatment of a mentally defective boy, "The Wild Boy of Aveyron," was begun in 1799 by Itard,[1] shortly after he was appointed physician to the new Institute for Deafmutes in Paris. Itard gained much insight into the problem of mental defects and effected significant improvement in the social behavior of the "wild boy," but failed completely in his ambition to make of the boy a normal human being. In 1839 Guggenbuehl[1] began the building of Cretin Treatment Institute, the Abendberg, in Switzerland and later admitted non-cretin mental defectives into his treatment program. His fame and pride brought him animosity and led to an official investigation. The official report presented by Vogt and Verdat established several facts: notably that normal children were kept from attending public schools by housing them at Abendberg and that not a single cretin had ever been cured. Howe, an American physician,[1] was impressed by the education of the handicapped children in Europe during his several visits there, and started the teaching first of the blind, then of the deaf-mute, and lastly of the mentally defective. His commission report was instrumental in establishing the Experimental School for Idiotic and Feebleminded Youth in South Boston, the forerunner of the Walter E. Fernald State School in Massachusetts. Seguin,[2] a student of Itard, came to the United States in 1850 and assisted Howe and Wilbur in establishing new institutions for the teaching and training of retarded children in Massachusetts, New York, Connecticut, Ohio, and Pennsylvania.

Submitted February 17, 1971.

Hospitals or Schools

The few private schools devoted to the teaching and training of the mental defectives were quickly filled to capacity, as people began to realize that there was hope for the mental defectives and that the majority of them could be trained if not educated. Since mental defectives occurred evenly distributed among all socioeconomic strata, parents of many mental defective children were unable to bear the financial responsibility of sending their defective children to private training

schools. As compulsory public education became generally accepted, state after state found it necessary to establish state facilities for the teaching and training of the defectives. At first they were called state schools and later changed to state hospitals and schools and more recently state institutions. The changing names reflects the changing function of these state facilities. The pioneers interested in the training of mental defectives were mostly young physicians: Itard was 25 years old when he started working with the "Wild Boy of Aveyron;" Guggenbuehl was 23 years old when he started building the Abendberg; and Howe was 31 years old when he started teaching the blind. They were all extremely enthusiastic and energetic and were almost insensitive to possible failures. They were not trained as educationists, and did not hestitate to employ unorthodox teaching and training methods in these special schools. Itard believed that the human mind was built up by experience and that experience was gained through the use of all senses, particularly hearing. Itard covered the eyes of the "wild boy" with thick bandages and made loud and varied noises to the boy's ears in his attempt to accentuate sensory experience to develop the boy's intellectual faculties. However, as most of the patients in the earlier institutions were mental defectives—cretins, cerebral palsies, epileptics, and mongoloids, organic organismic or brain defects defeated the unrealistic and exaggerated ambitions. The training schools became hospitals, where the ambitious pioneers still hoped to cure these children of their defects and to make them normal human beings.

Carotid-jugular anastomosis was tried to improve cerebral circulation to promote intellectual function. Beck, et al[3,4] proposed the establishment of a cervical carotid-jugular fistula to "revascularize" the brain to improve intellectual functioning. They claimed clinical improvement in 35 percent of the 125 patients who had the operation. However, other observers[5,6] noted that the carotid-jugular anastomosis not only lacked therapeutic value, but, when remaining patent, it was associated with adverse effects, such as increased intracranial pressure, pulsating exophthalmos, papilledema, etc. Most of the blood shunted from the carotid artery, passed through the transverse sinuses to the contralateral internal jugular vein without reaching the cerebral capillary circulation.

The Huge State Institutions

In the 110 years, from 1850 to 1960, one small private school for a little over a dozen pupils has expanded to 125 state-supported residential centers with approximately 200,000 people.[7,8] It is interesting to note that with the increasing demand for such training facilities and the assumption by the state of this responsibility, most states, if not all, built these schools or hospitals out in the country, miles away from the cities where the families of these children reside. The parents were often told to forget about their defective children with the assurance that the State would take care of the children until they died and that the "experts" would teach and train these children. Many of these state residential facilities became small cities or communities. Most state institutions have hundreds of acres of land with their own power plant, water supply, and farming operations. It is almost the rule for a state institution to have as many as 2,000 persons and not uncommonly 4,000 to 5,000 "residents." This has led to total isolation and segregation of the mentally defective persons from the mainstream of population.

With the adoption of compulsory public education and the expectation of every American completing 12 grades rather than 8 grades of academic training, more and more individuals were found to be incapable of meeting this arbitrary standard. These people are not mentally defective but are subnormal in their mental capability. They score in the lower 2.5 percent of the continuum in the mental capacity curve and are called mental retardates. With the introduction of the intelligence tests and the concept of intelligence quotient, many individuals who score low on the "intelligence yardstick" are classified as mental retardates and are placed together with the mental defectives in the state schools. Children, who come from socioeconomically deprived backgrounds, often score low on these standard tests and are also "branded" retardates. Thus the mental defectives, the mental subnormals, and the "real" mental retardates (persons who score retarded on psychometric testing but have potentials for normal functioning) are grouped under one name, mental retardates, and are housed in the state institutions.

To meet the needs of this large, heterogeneous population of children, youths, and even adults, the institute usually organizes three sets of programs: (1) medical and surgical unit for the treatment of medical and surgical complications often associated with severely and moderately retarded, mentally defective patients; (2) special

The Author

• **Dr. Ch'eng, Broadview Heights, is Superintendent and Medical Director, Broadview Center for the Mentally Retarded.**

class school unit for the teaching of "academics" to the "educable retardates," children representing the mental subnormals and retardates with emotional or behavioral disorders; and (3) industrial unit for the training of the institution "residents" in the operation and maintenance of the farm, ranch, laundry, power plant, kitchen, and miscellaneous daily chores at the institution. The medical and surgical unit often represents a "high-priced nursing home," which is filled with mostly chronic cases and a few acutely ill patients, unless there should be outbreaks of shigellosis, amebiasis, staphylococcus infections, or any of the common childhood viral diseases such as measles, mumps, and chickenpox. The special class school unit is often the show place of the institution with special classes not very different from the special classes in the public schools except that there are usually more pupils presenting behavior disturbances, such as stealing, using vulgar language, aggressive fighting among peers, and revolting against authority. The industrial unit serves a very important function in the operation of the entire institution. After years of training, many trainees become quite proficient in the operation of the farm, ranch, laundry, dietary, housekeeping, maintenance, and other departments. They often become indispensable members working side by side with employees in these various departments. Their performance on the job may equal or sometimes even excel that of the paid employees. They are given "incentive pays," which may be only a tenth of the salary or wage of paid employees. It is probably not too far from the truth to say that without these "residents" industrial service, many of the large state institutions would collapse or at least would face a catastrophy.

In the early 1960's, the vocational rehabilitation service extended its clientele to include individuals with emotional and mental handicaps. Many of the "industrial worker residents" in state institutions were habilitated and employed in the communities. In almost every case, it was necessary to retrain these "residents" in their mode of daily living and work attitude to "de-institutionalize" them. Many times they are capable of performing well on the job, but have poor social skills. They need to be taken to and from work stations. They talk back and argue with their employers and rarely make decisions on their own. A number of these habilitated retarded residents may test in the range of borderline or even dull normal intelligence on standard psychometric tests. It becomes necessary for the vocational rehabilitation services to raise the IQ level from 70 to 90 for mental retardation to justify the claim that their clients are "retarded" although their IQ scores are in the 80's and even low 90's. During this same period, the public school system is assuming more responsibility in the education of the "educable retardates" and, in a limited beginning, of the "trainable retardates." The public school system is also experimenting with unorthodox educational methods, such as the Montessori method and the work-study program. The less gifted youths, who are not prepared academically to enter college, are technically trained for employment in the community. The school system is also getting more actively involved in the treatment of behaviorally and emotionally disturbed school children. Therefore, within the next decade the state institutions for the mentally retarded can be expected to show a drastic change in the nature of the patient population. Only the severely and profoundly mental defectives with accompanying multiple physical defects or mental retardates with more severe behavioral and emotional disturbance will remain in the state institutions. The Developmental Disabilities and Facilities and Construction Act of 1970[9] may be interpreted as limiting mentally retarded to mentally defective, since they are grouped with cerebral palsied and epileptic under the general category of neurologic disease.

The Challenge of the Future

Should this trend of classifying mental defectives under neurologic diseases be generally accepted, the treatment of the mental retardates with behavioral and emotional disorders will have to be assigned to a separate facility more closely related to facilities for the treatment of mental illness. At the present time, the majority of these emotionally and behaviorally disturbed mental retardates present no evidence of neurologic disease or other physical defects. They score in the mild retardation range on standard psychometric tests, achieve academically below the fourth grade level in the public school system, and perform antisocial acts in spite of the verbal acceptance of a middle class social standard. Many of these youths come from socioeconomically deprived families. They are not delinquents and are, therefore, refused assistance by the Ohio Youth Commission. They are not psychotic and are usually considered incapable of benefiting from programs offered at psychiatric institutions, where the programs are designed for children of normal intelligence. These children generally are quite different from the mental defectives, and not uncommonly mistreat the mental defectives and practically always resent being grouped with them. They require psychologically oriented behavior modification programs and sometimes even psychiatric treatment.

The life span of the mental defectives has been steadily prolonged with the discovery and improvement in the medical treatment of acute intercurrent infections. However, medical science

today still presents very little hope of eradicating the basic disease. Even in the case of phenylketonuria, the most thoroughly studied example of inborn error of metabolism, where we think we have the "cure," we are unable to supplement the defective enzyme, phenylalanine hydroxylase. Many of these individuals have very little potential for development during the natural maturation process. Therefore, it is absolutely necessary and important to provide these defective individuals with optimal environment to further the development of whatever little potential they still possess. Studies of the development of normal infants,[10-12] reveal the tremendous importance of mother-infant interaction in motivating, supporting, and directing the infant's growth and development. The physical contact and cuddling of the mother provides a sense of security to the infant, and the infant's smile serves to endear him to the mother. This interaction enables the infant to learn about his own ego-boundary and the presence of a not always warm and kind external environment and gives him courage to grow and develop in the world of realities. Without this interaction, the infant will not develop normally and may even fail to survive. Studies of children with Down's syndrome,[13,14] show that such defective children kept in their natural homes developed motor skills and language earlier and functioned at a higher level than did those who were placed in institutions. The nursing personnel in most state institutes work eight hours a day and 40 hours a week. Thus it becomes unavoidable that the infant is cared for by six different adults, mother surrogates, in a ten-day period. The infant, who has to interact with six different women, will be confused, if not threatened, by this kind of environment, and his development will certainly be limited. The State of Ohio is fortunate in having an established rule that no mentally defective or retarded child shall be admitted for residence in a state facility before the age of 6 years.

What about the development of a defective child after the age of 6 years? To my knowledge there has been no report of such comparison between older defective children kept at home and those raised in institutions. One can only speculate that a more consistent, more or less permanent, adult-child relationship will offer a better environment for the defective child to develop his limited potentials than an ever-changing, inconsistent, and sometimes contrasting adult-child relationship. We have observed a few moderately to severely defective children, who failed to make much progress in developing self-care skills in a state institution within two years of residence but showed sudden improvement in these skills as well as improvement in group interaction after they were placed in small nursing homes. We are not sure that these happenings are anything other than natural maturation having no relation to the change of environmental assistance. The number is too small to offer conclusions but should certainly stimulate some careful consideration in the future. Nursing homes have been considered as depositories for mentally-ill patients who have received maximum help from state mental hospitals and are not able to improve further. The therapeutic potentials of a small nursing home have not received any consideration. Nursing homes, in general, will still be places where a patient can live with peace and dignity, when he suffers from a condition for which modern medical science offers no cure or hope of a cure. But a state-supervised, specially selected small nursing home, which takes care of approximately five mentally defective children, may be a more appropriate place to further the development of the potentials of a mentally defective child than the present state institution where a defective child may become no more than just a patient with a number.

We physicians started the care, teaching, and training of mentally defective children a little over 100 years ago. With the rapid changes taking place in the state institutions for the mentally retarded, are we not ready to involve ourselves again in planning better treatment facilities and environment for these helpless and hapless individuals?

Conclusions

1. In slightly more than 100 years, the facility for the care of mental retardates in the United States has grown from a small private school for less than 20 pupils to approximately 125 state supported residential centers with 200,000 people.

2. State training schools became state hospitals and schools and then state institutions. State institutions with the three major units: medical-surgical, special classes, and industrial training have to face the challenge of the public school system taking over the education of the "educable" and "trainable retardates" and of the vocational rehabilitation service taking over the training of the "industrial" workers.

3. A mentally defective child, who cannot be cared for in his natural home and requires no acute medical treatment in a hospital, may have a better chance to develop his potentials in a small nursing home under the supervision of the state institution. Such a state institution may be called State Institute of Developmental Disabilities, in accordance with the thinking stimulated by Public Law 91-517 (S-2846).

4. Emotionally and behaviorally disturbed mental retardates may be treated in a children

and adolescent psychiatric hospital where IQ shall be forever buried and never serve to exclude a less gifted child or youth from receiving proper psychiatric treatment.

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E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.*

A 12-year-old girl enters with the complaint of a swelling beneath her tongue. This mass has been present for several months and is gradually enlarging. It does not vary in size and is nontender.

Physical examination reveals a soft cystic mass located in the floor of her mouth (Fig. 1). Her tongue has excellent mobility. There are no enlarged nodes palpable in her neck.

What is your diagnosis and treatment?

(See p. 142 of this issue for further information and discussion.)

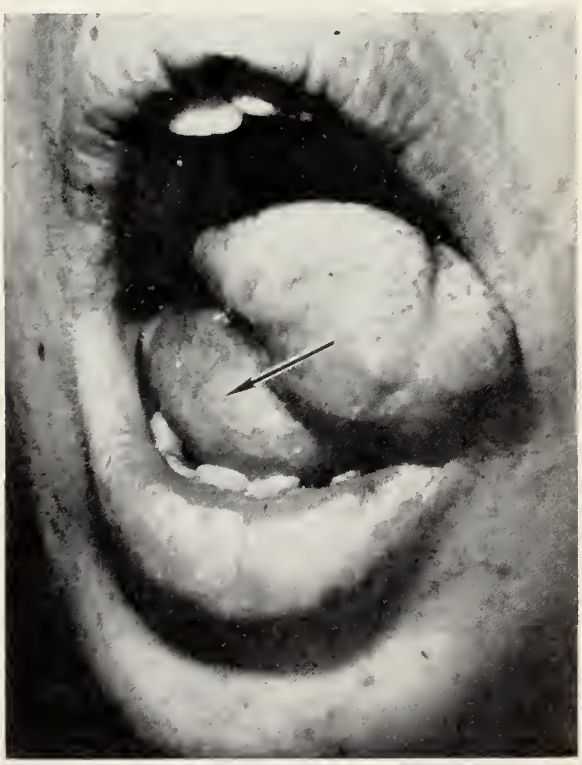


FIG. 1. Arrow points to soft cystic mass located beneath the tongue.

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Submitted March 31, 1971.

Radioisotope Scanning of Bone
A Review of the Literature

Joseph Schlonsky, M.D.

MAN HAS KNOWN for several years that certain radioactive materials accumulate in the skeleton. From 1917 to 1925, hundreds of watch workers inhaled or ingested radium, mesthorium, or radiothorium while painting luminous dials.[1] The harmful effects of deposition of these materials in the skeleton were first noted by Blum[2] in 1924 and Hoffman[3] in 1925. Many exposed workers developed bone necrosis, osteomyelitis, and osteogenic sarcomas several years after exposure.[4,5]

The original radioisotope animal experimentation was reported by Chiewitz and Henesy[6] in 1935. They used phosphorus (^{32}P) which labels the phosphate moiety of hydroxyapatite to demonstrate a rapid exchange of phosphate between plasma and bone. In 1942, Treadwell[7] reported using strontium (^{89}Sr), a pure beta emitter, as a tracer in osseous studies of malignant bone disease. Using autoradiographic technics, he found deposition of radioactive strontium in active osteogenic areas. In 1953, Bellin and Laszlo[8] reported the first study of calcium tracers in humans. They described the distribution and excretory pattern of calcium (^{45}Ca) after its oral and parenteral administration and hypothesized that changes in blood activity or excretory pattern might yield insight into skeletal metabolism of calcium.

With the invention of the cyclotron and nuclear reactors, nuclear physicists have been able to create new isotopes and elements for use in biological investigation.

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Submitted December 11, 1970.

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The Nature of Isotopes

An understanding of radioactivity[9] and the interaction of radiation with matter is only possible if we understand the concept of the atom.

The atom is composed of a small central nucleus and one or more orbiting electrons. The positively charged nucleus consists of a mass of protons and neutrons held together by cohesive forces and surface tensions. Protons have a positive charge equal in magnitude to the negative charge of an electron. Neutrons are like protons except they carry no charge and are slightly heavier. Both weigh approximately 1800 times an electron. Electrons are lightweight, orbit rapidly about their nucleus, and are held to the atom by the positive charge of the nucleus. The electrons are in constant motion at varying distances from the nucleus in shells centered about the nucleus.

The atomic number (Z) of an atom is the number of protons in its nucleus. The mass number (A) equals the number of protons (Z)

and neutrons (N) in the nucleus. Therefore, A = Z + N. Each different combination of Z and A represents a nuclide. All nuclides with the same proton number are isotopes of a specific element. Isotopes have the same (Z) number but different mass numbers (A); therefore, they must have different numbers of neutrons. The number and arrangement of nuclear particles determine the nucleus stability. Unstable nuclei will spontaneously change to a more stable form emitting radiation in the process. These unstable nuclei are called radioisotopes.

The hydrogen atom is found in nature in three forms: hydrogen, deuterium, and tritium. These atoms all contain one proton and one electron but contain none, one, and two neutrons respectively. This is an illustration of three isotopes of the hydrogen element.

Radioactivity is defined as the energy given off as radiation by an unstable nucleus seeking stability. Within the nucleus, an isomeric transformation of proton and neutrons or of their internal arrangement ensues. Nuclei emit energy in three forms: (1) alpha particles, (2) beta particles or electrons, or (3) gamma rays or protons.

Alpha and beta radiation are associated with decay of an element. Alpha decay is found only in the isotopes of heavy metals. The alpha particle is identical to the helium nucleus with two protons and two neutrons. As a result of alpha emission, the atomic number (Z) is reduced by two units and the mass number (A) is reduced by four units per decay. The alpha ray is a heavy particle with great kinetic energy.

Beta rays are high speed electrons produced in decay and may be either positively or negatively charged. Several radioisotopes emit the latter. Positive beta rays (positrons) have only a transitory existence. Beta decay results in formation of another element with a different atomic number but with the mass number being unchanged.

Gamma ray decay occurs when an atomic nucleus rearranges its internal structure to gain a state of lower energy. Gamma rays represent electromagnetic radiation emitted from the nucleus in the form of protons. Their physical properties are similar to x-rays of short wave length.

The penetrating power of alpha, beta, and gamma radiation varies tremendously.[10] Alpha and beta rays can be stopped by a sheet of paper and by about 1/25 inch of aluminum respectively. However, it takes several inches of lead to stop gamma radiation.

Radioactive scanning is useful in detecting, outlining, and localizing defects in internal organs. Ideally, an isotope is chosen that has selective affinity for the organ in question and emits gamma rays which are recorded by a scintillator moving over the indicated area. Bone scanning at the body's surface requires emission of penetrating radiation. This can be achieved by three methods: (1) employment of radioisotopes emitting gamma radiation, (2) production of radiation as a result of positron annihilation, and (3) by bremsstrahlung, the process by which a charged particle is deflected from its path or has its velocity changed and thus emits electromagnetic energy as photons.[11]

Isotopes Used to Scan Bones

Bone consists of a combination of organic and inorganic constituents which may be labelled with isotopes. Table 1 lists some of the radioelements that concentrate in these skeleton fractions.[12] Many of these isotopes emit beta radiation, which makes them suitable for autoradiography but not for scintimetry in vivo. Others have long half-lives and are unsuitable for short-term experiments. In clinical practice today, we primarily use the short-lived isotopes of strontium, fluorine, and gallium. The ease of obtaining ^{87m}Sr and ^{68}Ga by generator elution[13-15] and ^{18}F by cyclotron[16,17] have made these isotopes available for routine use.

Calcium (Ca)

^{45}Ca is a pure beta emitter with a half-life of 164 days. In 1942, Pecher[18] administered radioactive calcium to laboratory animals and noted the highest concentration in areas of new bone formation. ^{47}Ca is of greater clinical importance because it emits gamma rays and can be detected externally. It has a short half-life (4.7 days) but emits high energy gamma rays of 1.31 million electron volts (Mev). Lead shields and collimators in most hospitals are inadequate for scanning at this high energy, and this isotope is rarely used.

After radioactive calcium is injected in man, the serum specific activity drops exponentially during a 2 to 8 day period.[19] This observation is compatible with a model originally conceived by Carlsson[20] of two exchangeable compartments of body fluid and exchangeable bone and the third compartment of bone calcium accretion in which

Table 1. Radioisotope Affinity for Skeletal Part

Organic Matrix	Americium, plutonium, yttrium, zirconium, niobium, lanthanum, proseodymium, neodymium, promethium, samarium, europium, neptunium, actinium, cerium
Inorganic Mineral	Calcium, gallium, strontium, uranium, radium, magnesium, lead, phosphorus, sodium, barium
Ground Substance	Sulphur

tracer is irreversibly deposited in the process of new bone formation.

The reader is referred to the reviews of calcium kinetics by Heaney,[21] Eisenberg,[22] and Dow[23] for further information on this esoteric subject.

Strontium (Sr)

Investigators[24-27] generally agree that strontium concentrates in bone and that its metabolism is very similar to calcium. Although there is no significant metabolic discrimination, there are quantitative differences in the metabolism of the two elements in the gastrointestinal and renal systems. Studies indicate that the skeleton retains less strontium than calcium due to preferential gastrointestinal tract absorption of calcium and preferential excretion or decreased resorption of strontium by the kidneys.[28,29] The early studies used ^{89}Sr and ^{90}Sr, which are pure beta emitters and thus unusable for external scanning. ^{85}Sr was available by 1959 and Bauer[30] noted increased uptake of ^{85}Sr and ^{47}Ca in numerous clinical diseases including fractures, neoplasms, Hodgkin's disease, osteomyelitis, and eosinophilic granulomas. ^{85}Sr decays to rubidium (^{85}Rb) with a single gamma emission of 0.513 Mev. However, it has several disadvantages.[31] Its 64-day half-life and slow turnover rate preclude repetitive studies. Fecal excretion requires enemas. Doses are limited by the Atomic Energy Commission for clinical investigation of patients with diagnosed cancer.

In 1960, Myers[32] introduced ^{87m}Sr as a substitute for ^{85}Sr. It reduced the radiation dose to less than 1 percent of the ^{85}Sr dose. It decays with emission of a single gamma ray of 0.388 Mev to stable ^{87}Sr. With its half-life of 2.8 hours, scans are performed 45 minutes after injection, even though 50 to 70 percent of the dose is not taken up by bone and remains in the circulation.[33,34] Nevertheless, the ^{85}Sr and ^{87m}Sr scans are remarkably similar if not identical.[33] Occasionally a false positive or negative result may occur when compared to a later scan with ^{85}Sr.[35] The disadvantages include the short 80-hour half-life of the yttrium (^{87}Y) cow, cost of the generator, and time-consuming preparation of the isotope.

Fluoride (F)

^{18}F can be produced by either cyclotron or reactor. It was introduced in 1962 as a nuclide especially suitable for scintigraphy.[36] It can only be used close to a cyclotron or reactor because of its short half-life (1.87 hours). ^{18}F emits a 0.65 Mev positron and positron annihilation provides suitable radiation for scanning. Although the fluorine dose is relatively large compared to ^{85}Sr, there is very little radiation threat to the patient. The fluorine radiation dose to bone is 1/200 that of a comparable dose of ^{85}Sr.[37] In addition ^{18}F is more rapidly cleared from the soft tissue and blood than ^{87m}Sr. This yields in higher tumor-background ratio. After intravenous injection, the fluoride ion is absorbed in the skeleton by anion exchange for the OH group in hydroxyapatite at the surface of bone crystal. This presumably occurs in regions of good blood supply and increased mineral turnover.[38] This differs from strontium, which is incorporated into bone by exchange with or along with calcium ions in crystals. In tracer amounts, about 50 percent of the fluorine dose is fixed in bone, and the other half is cleared by renal excretion.[36] For pelvic scanning ^{18}F has the obvious disadvantage of accumulating in the bladder. ^{18}F has been compared with ^{85}Sr, ^{87m}Sr, ^{47}Ca, and ^{68}Ga in recent papers and found to be the superior radionuclide for bone studies.[39-41] The preference for ^{18}F over ^{87m}Sr is not shared by Spencer.[42]

Gallium (Ga)

The bone-seeking property of ^{72}Ga was described by Dudley[43,44] in 1949. Gallium is thought to substitute for calcium in newly formed bone crystal.[45] ^{72}Ga has been used to demonstrate bone lesions and tumors[46] but has been discontinued because of undesirable radiation dosage and toxicity. ^{68}Ga is a positron emitter with a 68-minute half-life. However its gamma energy is not ideal and investigators have questioned the equivocal safety of stable gallium.[47] ^{67}Ga has been found to deposit in a variety of malignant neoplasms including some non-osseous tumors.[48] It has a half-life of 78 hours and emits moderate energy gamma rays suitable for available scanners. Gallium is known to bind to certain proteins[49] but the mechanism for its binding to soft tissue tumors is unknown.

Marrow Scanning

Bone marrow scanning is a recently introduced field of nuclear medicine. The bone marrow organ is difficult to study because of its dispersion about the body and varying proportions of fatty and hematopoietic tissue. The ability to delineate bone marrow with radioactive colloids was first demonstrated by Engstedt, et al[50] in 1958. Responses to marrow destruction, hyperplasia, local lesions, and extension of active marrow into extremities have been demonstrated.[51-53] Radioactive colloids are phagocytized by the reticuloendothelial system primarily in the liver, spleen, and bone marrow. The vast majority of the colloid is deposited in the liver and spleen with only about 10 percent being distributed in the bone marrow. Furthermore, alterations in the blood supplies of

the liver and spleen affect the volume of colloid reaching the marrow. Fatty fibrous marrow and that replaced by tumor give a cold scan whereas normal or hyperplastic marrow take up colloid. Leukemic marrow has yielded variable results.[47]

At the outset, colloidal gold (^{198}Au) was the scanning agent of choice. It has lost popularity because of its high radiation exposure. At present, sulfur sol colloid labeled with technetium (^{99m}Tc) is widely used because of its easy preparation, short half-life (6 hours), and gamma emission at 0.14 Mev without beta emission (low radiation exposure).

The most specific use for marrow scanning is in myelofibrosis, a diagnosis sometimes difficult to establish. In other disorders destroying marrow of the trunk such as multiple myeloma, Hodgkin's disease, and acute leukemia, compensatory regenerative marrow activity of the extremities particularly about the knee may be seen.[47]

Obvious disadvantages to marrow scanning include its high uptake by liver and spleen precluding spine scanning in this area and the knowledge that certain bones such as the ribs and skull have little marrow content.

Bone Tumors

Treadwell, in 1942, demonstrated increased uptake in osteosarcoma, Ewing's sarcoma, and metastatic bone lesions from the prostate and breast.[7] Nevertheless, it was not until the 1960's that moderate-sized clinical series of bone scintigraphy were published demonstrating the value of isotopes in detecting bone tumors. A skeletal tumor usually causes an active proliferation of new bone formation in reaction to tumor invasion. The lesion will be roentgenogram lytic if bone destruction exceeds bone repair and sclerotic if anabolism is greater than catabolism. The scan depicts the activity of the reactive process, whereas the x-ray film shows the net changes which have occurred.[34] In 1961, Gynning[54] administered ^{85}Sr to patients with breast cancer and concluded that this procedure was valuable because it occasionally demonstrated metastases before they were seen on roentgenograms. The roentgenographic diagnosis of metastatic cancer in trabecular bone is difficult because a 30 to 50 percent decrease in bone calcium content is necessary before lesions are detectable on x-ray film.[55,56] Moreover, lesions must be 1 to 1.5 cm in diameter in vertebra before they are seen on x-ray film.[55] Several authors[33,57-61] have demonstrated the ability of scintigraphy in detecting the occult metastatic lesion. Simpson and Orange[62] made ^{85}Sr scans on 46 patients with skeletal pain but with normal roentgenograms. Positive scans were found in 34 patients, 20 of whom were subsequently found to have metastases. Of 12 patients with negative scans, three ultimately developed metastases and six did not. Final evaluation was not possible in 14 patients. Briggs[63] had a similar experience scanning 83 patients with known malignant disease. Thirty-four of 47 "hot" scans were found to have malignant metastases. The scan findings were confirmed in 72 percent of cases, which compares with 70 percent of cases reported by Simpson. False positive tests may result from scanning nonmalignant disease entities, scanning joints, and high background counts. Furthermore, investigators[63,64] generally agree that the false negative scan rate is less than 5 percent. They may be caused by high anaplastic neoplasms, static lesions, minimal tumor growth, diffuse spinal metastases, and technical errors during scanning. Scans were positive in 15 percent of patients with normal roentgenograms in Parsons' series.[60] In more selective tumors such as prostatic carcinoma, the incidence of positive scans with normal x-ray films and occult metastases is about 48 percent.[59,65]

The literature indicates that the bone scan's greatest usefulness in malignant tumors is in diagnosing the radiographic occult tumor and in outlining the extent of tumors. The scan's value in postoperative long-term tumor assessment is still equivocal. They are also useful in evaluating the asymptomatic patient with minimal lesion shown on x-ray films, in differentiating traumatic from pathologic fractures, in evaluating response to radio- and chemotherapy, and in staging tumors.

Fractures

For the past 25 years, investigators have demonstrated high uptake of radiostrontium, calcium, and phosphorus over fracture sites in laboratory animals. In 1945, Marshak & Byron[66] found the maximum isotope uptake over surgically created rat tibia fractures was 8 to 15 days after the fracture. McDonald[67] noted a fracture-intact tibia isotope uptake ratio of eight, 10 to 25 days after tibia fracture in a rabbit. Falkenberg[68] found maximal ^{85}Sr uptake in fractured radii of rabbits two to three weeks after fracture; this was six times higher than in normal bone. In 1955, Bohr[69] reported an increased ^{32}P uptake six months after a femur fracture in a rat. Isotope experiments in fractures have shown that an increased deposition of bone salts in the callus is accompanied by an increased resorption and increased accretion of bone salt in surrounding bone. The bone salt deposited in the callus is bound by an irreversible process, so that the amount of radioactivity measured in the callus is proportioned to the amount of newly formed bone salt.[68]

The classic study of isotope uptake in human fractures was written by Wendeburg[70] in 1961.

He scanned tibia fractures periodically with ^{85}Sr and ^{47}Ca and reported an increased accretion rate as early as one week after fracture and uniformly after two weeks with radioactivity increasing rapidly to peak at six to eight months after fracture. At this time the radioactivity was 7 to 30 times the values of the contralateral tibia. Six to nine years later, the uptake had not returned to normal despite the fact that some of the fractures were not identifiable on x-ray film. He also reported that no difference was noted in the accretion rates of delayed and nonunited fractures as compared with normal healing fractures. The corollary is that the scan cannot prognosticate whether or not a fracture will unite. This would agree with Urist, Mazet, and McLean,[71] who concluded "there is never an end to the progress and effort of healing" in human tibial pseudarthrosis and that "osteogenesis progressed steadily all around the fracture gap but never across it."

Vertebral fractures have been recently reported with initial uptake of ^{85}Sr returned to normal 6 to 18 months after fractures.[72,73] This is probably indicative of the shorter amount of time needed to heal cancellous as compared to cortical bone.

Use of Radioisotopes in Studying Femoral Head Viability

The problem of aseptic necrosis of the femoral head has been difficult from the aspect of early diagnosis and treatment. It occurs in 18 to 33 percent of femoral neck fractures[74-76] and in 15 to 30 percent of hip dislocations or fracture dislocations.[77] It is also a complication of slipped femoral epiphyses, several hematologic and metabolic diseases, as well as patients chronically using alcohol and steroids.

The earliest possible diagnosis of avascular necrosis is imperative for optimal treatment. However, standard roentgenographic methods may delay the diagnosis up to four years.[78] Therefore, other methods including thermography, histology, dye clearance, isotopes, tension measurements, etc, have been tried without dramatic success. These have been previously summarized in the literature.[79,80]

In the past two decades, several[81-85] investigators have employed phosphorus radiotracers in attempting to predict femoral head viability after intracapsular fracture. One method measured uptake of the isotope at surgery with results being expressed as a trochanter-head ratio. In 1950, Tucker[85] originally reported this method and concluded that satisfactory healing took place when the trochanter-head ratio was 3:1, whereas a ratio of 10:1 was evidence of impending avascular necrosis. Arden and Veall[82] reported spurious results due to (1) contamination of the bone specimen by radioactive blood, (2) increased time interval between isotope administration and sample removal, (3) variations in samples in various parts of the femoral neck, and (4) delay in removal of specimens since the ^{32}P content of bone progressively increased. They concluded this technic was of no benefit because of technical difficulties and poor clinical correlation. Boyd and Calandruccio[83] reported the critical trochanter-head ratio to be 4:0 and believed that the uptake studies were of prognostic value in two thirds of the patients with displaced fractures of the femoral neck. Laing, et al [86] studied the usefulness of ^{32}P as an indication of femoral head vascularity in rabbits. They concluded that accurate evaluations were difficult due to the fact that ^{32}P uptake provides an index of availability of radiophosphorous to the bone crystal rather than an indicator of viability. They also pointed out it may be interpreted as an index of the relative proportion of cortical to cancellous bone with its trapped marrow in any given area.

Another major method of radioisotope study employed injection of radiotracers into the femoral head at the time of surgery followed by measurements of its clearance from bone.[87-89] High clearance rates were equated with normal vascularity and low with decreased vascularity. The use of ^{131}I was preferable to ^{32}P and ^{24}Na which interact with ions at bone crystal and local tissue fluids, respectively.[90] This method is reported to have greater than 80 percent accuracy.[87,88]

The methods cited in the preceding two paragraphs have obvious disadvantages. They must be performed during surgery necessitating that detection devices be moved to the surgical suite and prolonging anesthesia time. Pre- and postoperative serial scans are denied. Intramedullary injection of the radionuclide into the femoral head is technically difficult and takes practice. The hazard of leakage and damage to the intramedullary vasculature by excess injection pressure are further problems.

In 1964, Massie[76] developed a fenestrated sliding nail to follow hip fractures after open reduction metallic fixation during their convalescent period. The patient's red cells were tagged with ^{32}P preoperatively. Serial readings were taken at surgery by a detector placed in the appropriate fenestration. Percutaneous readings were taken at weekly intervals postoperatively in the femoral head and in the neck distal to the fracture line. If the uptake ratio was less than normal at surgery and remained unchanged or less during convalescence, avascular necrosis uniformly developed. Studies at one month indicated this method had a diagnostic accuracy of better than 90 percent. However, single determinations at the time of

surgery were only 40 percent accurate. These studies further indicated that a normal rate at surgery was basis for optimism but that a decreased rate was not necessarily a poor prognosis.

Weber, et al[91] feel that colloidal tracers such as technicium (^{99m}Tc) are promising in demonstrating intact blood supply of the femoral head. They point out, however, that femoral head uptake is less than femoral shaft uptake and that resolution is difficult to perceive.

Other Clinical Uses of Bone Scans

Pathologic processes other than neoplasms, fractures, and aseptic necrosis have been studied by scintigraphy.

Danielsson and co-workers[92] studied more than 100 *osteoarthritic* hips with ^{85}Sr and ^{47}Ca scintimetry. They concluded that osteoarthritic hips had higher uptakes than normal hips and that these values were directly proportional to the severity of the disease as determined by x-ray study. In an extreme case, a tenfold increase in uptake was noted. Significantly higher values were demonstrated in osteoarthritis of recent origin as compared to chronic duration. The authors furthermore demonstrated that increased isotope uptake may precede other laboratory and roentgenographic parameters of arthritis. Increased uptake of radionuclides have also been demonstrated in osteoarthritis of the spine[93] and knees.[94] In genu varum deformity secondary to osteoarthritis, there is localized ^{85}Sr uptake over the medial tibial plateau. These values may return to normal after wedge osteotomy.[95]

In *rheumatoid arthritis,* synovial joint scans with strontium, ^{99m}Tc pertechnetate, and radiotagged albumin have shown increased uptake. Scans have been "hot" prior to roentgenographic changes.[96-98] Scanning can be employed to demonstrate the site and progression of disease as well as its response to therapy. The isotope uptake is diffuse involving the entire joint as contrasted to the focal, asymmetric scans of osteoarthritis. The mechanism of increased uptake is thought to be due to the increased permeability of the inflamed synovium. Of the agents used, ^{99m}Tc is the agent of choice as it attaches to the patient's own protein in transit through the vascular system and gives high counts with low dosage.[97]

Several authors have reported "hot" scans in *bone infections.* Fellander and Lindberg[99] have demonstrated increased uptake of ^{85}Sr in septic and tuberculous processes in the spine. Dymling and Wendeberg[100] have shown the value of the scan in osteomyelitis. External counting gave reliable information earlier than roentgenogram. Increased uptake of radionuclide greater than twice normal was uniformly demonstrated 14 days after the onset of symptoms in their series.

Paget's disease, with its localized highly vascular involvement of bone together with regions of osteolysis and new bone formation gives exceedingly high values (5 to 10 percent) of isotope uptake.[101] The accretion rate is elevated in hyperparathyroidism and below normal in hypoparathyroidism.[102] In the former the increased accretion is proportional to the roentgenographic skeletal changes presumably due to bone resorption. Dymling[102] found no kinetic difference between parathyroid hyperplasia and adenoma.

There are scattered reports of increased isotope uptake in *hyperthyroidism,*[103] *pseudogout,*[40] *vitamin D-resistant rickets,*[103] *eosinophilic granuloma,*[33] and *lymphomas.*[48] Low accretion has been reported in *osteomalacia,*[104] *rickets,*[104] *multiple myeloma,*[95] *hypovitaminosis* D,[95] and *idiopathic osteoporosis.*[102] Bauer[95] has summarized some of the observed accretion rates in a variety of clinical entities in his review article in 1968.

Summary

Bone scans are based on a disturbance of bone mineral metabolism. Positive scans are not pathognomonic of any specific disease entity. The scans indicate the dynamic state of bone while plain films show the net changes, both osteolytic and reparative, that have occurred. When correlated with roentgenographic, laboratory, and clinical data, scans may add useful information to the clinician. The principal use of scintigraphy today is in detecting occult neoplasms in bone, investigating bone pain, clarifying the nature of known osseous lesions, and studying fractures.

Editor's Note: Due to space limitations, the list of references indicated by number in the text is omitted in this printing. The reference list will be furnished by the author upon request to him at The Ohio State University Hospitals, Division of Orthopaedics, 410 West Tenth Ave., Columbus, Ohio 43210.

Choledochoduodenal Fistulae Complicating Chronic Duodenal Ulcers

Report of Three Cases

Jose Espinosa, M.D.; Peter J. Cohn, M.D.; and Howard M. Gans, M.D.

CHOLEDOCHODUODENAL FISTULA complicating chronic peptic ulcer disease is a relatively rare clinical entity. Epperson and Walters[1] reported 84 cases of internal biliary fistulae, and of these, three were caused by duodenal ulcers perforating into the common bile duct. Although the vast majority of internal biliary fistulae are secondary to calculus biliary disease, those communications between the common duct and the duodenum are usually secondary to penetrating posterior duodenal ulcers. Borman and Rigler[2] reviewed 16 cases of choledochoduodenal fistulae and reported that 14 were caused by duodenal ulcers. Lewis and Bohrer[3] reported 13 cases of choledochoduodenal fistulae of which 12 were caused by chronic duodenal ulcers. Hutchings et al[4], in a review of 28 cases of choledochoduodenal fistulae, all secondary to penetrating duodenal ulcers, report that these fistulae account for between 10 to 20 percent of all internal biliary fistulae.

In the past two years, we have treated three cases of choledochoduodenal fistulae secondary to chronic duodenal ulcer.

Case 1. This 55-year-old white man had a 25-year history of intermittent epigastric pain. He had been told that he had a peptic ulcer, and he had received periodic medical treatment. For four days prior to admission, he had continuous epigastric pain and intermittent vomiting. There was no history of chills, fever, hematemesis, or melena. Physical examination was unremarkable.

Admission laboratory studies, including hematocrit, white blood cell count (WBC), blood glucose, blood urea nitrogen (BUN), serum bilirubin, amylase, total proteins, cholesterol, alkaline phosphatase, and urinalysis were normal.

An upper gastrointestinal x-ray series performed a few days prior to admission revealed a large posterior duodenal ulcer with a fistulous communication to the common bile duct (Figs. 1 and 2).

At surgery, a large posterior duodenal ulcer was found adherent to the distal common bile duct. The common duct was opened, and a long limb T-tube (Cattel tube) was used to stent the distal duct and entered the duodenum via the ampulla of Vater. A vagotomy and Billroth II hemigastrectomy were then performed. Postoperatively, the patient developed phlebitis of the left calf, which responded to anticoagulant therapy. He was discharged on the 26th postoperative day and has remained asymptomatic over a two-year follow-up.

Comment: In this case, the surgeon was able to establish patency of the distal common duct by passing a Cattel tube through the ampulla of Vater.

Case 2. This 60-year-old white man had a history of intermittent epigastric discomfort for 30 years. A pyloroduodenal channel ulcer was demonstrated radiographically in 1964; however, the patient refused surgery

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FIG. 1. (case 1) Demonstrates large posterior duodenal ulcer with choledochoduodenal fistula. Twenty-five year history of duodenal ulcer.



FIG. 2. (case 1) Upper gastrointestinal series clearly demonstrates filling of distal common duct through choledochoduodenal fistula.

and instead received x-ray therapy to the stomach in an attempt to reduce gastric acidity.

One week before admission, he again had severe epigastric pain, and upper gastrointestinal roentgenograms revealed a channel ulcer with a fistulous communication to the common bile duct (Fig. 3). While awaiting hospital admission, he developed chills, fever, and right upper abdominal pain. Treatment with antibiotics was initiated for ascending cholangitis.

Examination on admission revealed a temperature of 103F and slight right upper abdominal tenderness. The white blood cell count was 10,000 per cu mm. All other laboratory studies were normal.

After five days of intravenous antibiotic therapy, the patient was afebrile, and the abdominal examination was unremarkable. Surgical exploration was undertaken. The common bile duct was explored, and a Bakes dilator was passed across the ampulla into the duodenum. A vagotomy and Billroth II type hemigastrectomy were then performed. An attempt to pass a Cattel tube through the common duct and across the ampulla of Vater was unsuccessful and the duct was closed over a standard T-tube. The postoperative course was entirely uneventful. A T-tube cholangiogram performed ten days postoperatively showed normal egress of dye into the duodenum with apparent healing of the choledochoduodenal fistula (Fig. 4). He was discharged on the 24th postoperative day. The T-tube was removed two weeks later, and the patient has remained asymptomatic for over one year.

Comment: In this case, it was impossible to stent the entire distal duct with a Cattel tube. Although there is some narrowing of the distal duct on postoperative cholangiography, the patient has had no symptoms of ductal obstruction during the past year. If necessary, the distal duct could be by-passed via a gallbladder-small bowel anastomosis at a future date.

Case 3. This 64-year-old white man had a 46-year history of peptic ulcer disease with intermittent episodes of epigastric pain. He had one episode of bleeding 29 years prior to admission. Fifteen years ago, he received x-ray treatment to the stomach in an attempt to reduce gastric acidity. Thirteen years ago, upper gastrointestinal roentgenograms showed a choledochoduodenal fistula. Seven years before this admission, gastrointestinal roentgenograms again showed the fistula (Fig. 5). He had no symptoms of cholangitis and was managed on conservative ulcer therapy. Repeat x-ray films over a 13-year period showed nonhealing of the fistula and persistence of the ulcer. For three months prior to admission, he had severe epigastric pain, awakening him from sleep and necessitating almost continuous anti-acid therapy. He was admitted for elective surgery.

Physical examination was unremarkable. Hematocrit was 42 percent and white blood cell count was 11,000. All other blood determinations were within normal limits. A gastric analysis revealed elevated free and total acid with a strong histamine response. Upper gastrointestinal roentgenographs performed a few days prior to admission revealed air in the biliary tree with a deformed duodenal bulb and a 6 to 8 mm ulcer crater. There was also slight delay in gastric emptying (Fig. 6).

At surgery, there were dense adhesions and scarring around the distal common duct and first portion of the duodenum, precluding dissection in this area. Vagotomy and gastroenterostomy were performed, and the patient had an uneventful recovery. He was discharged on the 11th postoperative day. Follow-up to this date is only five weeks.

Comment: This case demonstrates an alternative surgical approach when technical difficulty precludes gastric resection. Although no barium is



FIG. 3. (case 2) Gastrointestinal x-ray film showing channel ulcer with choledochoduodenal fistula. Gallbladder also fills with barium.

seen in the common duct, the presence of air in the biliary tree confirms the presence of the choledochoduodenal fistulae.

Discussion

The diagnosis of internal biliary fistula, either secondary to biliary calculous disease or peptic ulcer, is seldom made on a clinical basis. There is usually nothing specific in these patients' histories to indicate that a fistula has developed. Although in patients with biliary calculi there usually is a long history of stones before formation of fistulae, Pitman and Davies[5] reported four cases of internal fistulae in which the history of biliary stones was less than one year. In choledochoduodenal fistulae secondary to peptic ulcer, the symptoms are usually those of the underlying ulcer disease.

In reporting 28 cases of choledochoduodenal fistulae secondary to peptic ulcer, Hutchings et al[4] found the average history of ulcer disease to be 11.1 years prior to demonstration of a fistula. In 14 cases reported by Lewis and Bohrer,[3] the average duration of ulcer history was 7.2 years. All authors agree that choledochoduodenal fistulae occur primarily in men. Hutchings et al[4] had all men in their series, and Lewis and Bohrer[3] reported only one woman out of a series of 14 cases. Our three cases are all men with an average ulcer history of 29 years prior to demonstration of a choledochoduodenal fistula.

Ascending cholangitis is a rare finding with choledochoduodenal fistulae. However, when present, it may offer a clue to the diagnosis, if barium swallow x-rays have not yet been performed. Case 2 in our series had an episode of ascending cholangitis; however, the diagnosis of choledochoduodenal fistula had already been made from upper gastrointestinal x-ray films.

Lewis and Bohrer[3] reported that in their series the ulcers were usually located superiorly in the first portion of the duodenum; however, in our three cases the ulcers were all of the posterior penetrating type.

Although some choledochoduodenal fistulae will heal with nonsurgical management, most will not, and protracted attempts at medical therapy may be complicated by scarring and obstruction of the distal common bile duct or by ascending cholangitis. Hutchings et al[4] state that the distal common duct scarring and obstruction may in effect cause the fistula to remain open as a vehicle for biliary drainage. Lewis and Bohrer[3] report ascending cholangitis in one of their cases, and case 2 in our series required treatment with antibiotics for ascending cholangitis prior to surgery. Two of our cases had received x-ray therapy to the stomach in an unsuccessful attempt to offer nonsurgical treatment for their ulcers. One can only speculate whether or not the irradiation affected the formation of the choledochoduodenal fistulae.



FIG. 4. (case 2) Postoperative T-tube cholangiogram shows egress of dye into duodenum with some narrowing of distal common duct. Patient asymptomatic for over one year postoperative.

Most authors believe that surgical therapy is necessary in cases of choledochoduodenal fistulae and that surgery should be directed at healing the



FIG. 5. (case 3) Upper gastrointestinal x-ray film, taken seven years before surgical treatment of the choledochoduodenal fistula, shows barium in biliary tree.



FIG. 6. (case 3) Arrows depict air in biliary tree on preoperative upper gastrointestinal x-ray film. Fistula still present after seven years of medical therapy.

ulcer and diverting gastrointestinal contents away from the fistula. We agree with Hutchings et al[4] that it is also important to explore the common duct to assure that it is not distally obstructed by an inflammatory process or by fibrosis. In two of our cases, the common duct was explored and in one of these a Cattel tube was passed through the ampulla of Vater. The technical aspects of surgical intervention are usually complicated by dense adhesions and scarring involving the distal common bile duct and the proximal duodenum. We believe that, when technically possible, the procedure of choice for definitive treatment consists of common duct exploration, Billroth II-type hemigastrectomy, and truncal vagotomy. This procedure will assure patency of the distal common duct and protect it from injury. It will also divert gastrointestinal contents from the fistula and allow healing of the chronic duodenal ulcer. In two of our cases, this operation was successfully employed, while in the third case technical difficulty prohibited gastric resection and vagotomy and gastroenterostomy were performed.

Our three patients all left the hospital symptom-free. Patient 1 has been asymptomatic for three years and patient 2 has been asymptomatic for over one year. Our third patient was discharged only five weeks ago. None of our patients had postoperative gastrointestinal roentgenograms; however, a T-tube cholangiogram performed ten days postoperatively in case 2 showed apparent healing of the choledochoduodenal fistula with some narrowing of the distal common bile duct (Fig. 4).

Summary

1. Three cases of choledochoduodenal fistulae secondary to chronic penetrating duodenal ulcers are presented.

2. There were no characteristic symptoms to indicate formation of a fistula in any patient and all fistulae were diagnosed by upper gastrointestinal x-rays.

3. Two of our patients had received irradiation to the stomach in an unsuccessful attempt to decrease acidity and facilitate healing of their ulcers.

4. One of our patients demonstrated ascending cholangitis secondary to a choledochoduodenal fistula.

5. The principles of surgical management of choledochoduodenal fistulae are presented.

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The Melkersson-Rosenthal Syndrome

A Case Report

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In the field of observation, chance favors the mind that is prepared.
(Claude Bernard)

RECURRENT OR PERSISTENT EDEMA of the face should be recognized as a possible manifestation of the Melkersson-Rosenthal syndrome. This relatively rare complex of symptoms was initially reported by Mart in 1859, Hubschmann in 1894, and subsequently by Rossolimo in 1901, who first noticed simultaneous occurrence of swelling of the upper lip and facial hemiparesis. It was Melkersson who first proposed a relationship between the facial edema and the facial paralysis in 1928.[1] Rosenthal in 1931 presented similarly afflicted patients, who also developed a peculiar fissuring of the tongue which he labelled "lingua plicata." Since these early descriptions, other abnormalities have been associated with the syndrome, including migraine headache, hypo- or asialia, hyperpigmentation of the face, and peculiar nodules of the hard palate (uranitis granulomatosa). While the Melkersson-Rosenthal syndrome has received extensive exposure in the European literature, such case reports and informative articles have been rare in the United States. It is apparent now that the macrocheilia described by Conway in 1938 was in fact the first description of this syndrome in the American literature.[2] Incomplete forms of the Melkersson-Rosenthal syndrome may often pass undetected, accounting for its lack of widespread recognition. The "formes frustes," as reviewed by Klaus and Brunsting,[3] are usually seen in any combination of two or more of the classic triad: facial edema, facial paralysis, and lingua plicata. The following patient probably displays such an incomplete phenotype. It must be remembered that the various disorders of this rare syndrome may precede one another by several years.

The Authors

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Case Report

The patient, a 25-year-old white electrician, first presented in February 1970 with swelling of the upper lip and nodules of the hard palate. The lip edema had begun as an intermittent phenomenon approximately three years before and had gradually become a permanent enlargement. The palatal nodules had only been present for about six months. The patient denied having injured either the lip or the palate. Although he had no history of allergies, he had been treated with antihistamines by two physicians who labelled the condition "probably allergic." This treatment had no apparent effect on the progressive facial deformity. Despite the facial and oropharyngeal edema this burly young man enjoyed excellent health otherwise. He followed a rigorous schedule

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of hard work and regular work-outs at the local gymnasium. He specifically denied facial paralysis, headaches, hyperhidrosis, and dryness of the mouth. No other similar condition was known to have occurred in any member of his large family.

The most striking finding on physical examination was the gross enlargement of the upper lip (Fig. 1). This edematous macrocheilia terminated vaguely in the nasolabial fold area bilaterally. The entire palate and oropharynx were markedly swollen. In addition, multiple varisized nodules from 0.1 to 0.8 cm were scattered over the hard palate (Fig. 2). No deficit in facial nerve function was noted. The tongue was normal in texture, lacking any features of lingua plicata. A biopsy of the largest palatal nodule was performed. Microscopic examination revealed chronic (granulomatous) inflammation. Several granulomas composed of histiocytes and occasional multinulceated giant cells were noted. Apprised of these findings the patient returned regularly for observation over the next three months. No changes were noted in the lip, palate, tongue, or facial nerve function. In November 1970, a cosmetic cheiloplasty was performed under general anesthesia. The surgery consisted of a lenticular resection of the central portion of the hypertrophied upper lip. It was not necessary to resect bilateral vertical wedges as recently described by Moully.[4] The lip healed per primum, affording improvement in appearance which has been most satisfactory to the patient (Fig. 3).

Histopathology

The histologic changes were comparable to those described by Hornstein.[5] The surface epithelium of the vermilion border was not remarkable. Widespread patchy infiltrations of mononuclear cells were seen throughout the dermis. Predominantly perivascular in distribution, these nonspecific infiltrations were principally lymphocytic in composition with occasional plasma cells and histiocytes. Several well-defined granulomas composed of histiocytes and multinulceated giant cells were noted in relation to capillaries and lymphatics (Fig. 4). The granulomas were sarcoid-like, showing neither confluence nor necrosis. No mycobacteria were identified by acid-fast and fluorescent technique. No fungi were seen with para-aminosalicylic (PAS) staining. Mast cells demonstrated by toluidine blue and PAS stains were conspicuous and as many as eight were seen in a high power field. Prominent angiectasis was obvious although tissue edema was not significant.

Mast cell prominence was also noted in a recent paper by Hallett and Mitchell.[6] The relationship of mast cells to focal edema, such as associated with urticaria pigmentosa, may possibly be extended to the Melkersson-Rosenthal syndrome, but further discussion of this speculation is beyond the scope of this paper.

Discussion

The etiology of the Melkersson-Rosenthal syndrome remains a mystery. No sex differentiation has been noted. The condition may occur at any age although it most often begins before the age of 20 years. The facial nerve involvement when





Fig. 1. Preoperative appearance of patient demonstrating grossly edematous macrocheilia.



Fig. 2. Numerous rounded, smooth nodules cover hard palate (uranitis granulomatosa).

present is not unlike, if not identical to Bell's Palsy.[7] Linking the two, facial palsy and edema, has been the suggestion that both are the result of autonomic nervous system dysfunction; presumably a paresis of the vascular supply to cranial nerve VII could account for both the palsy and the facial edema. The palatal nodules are probably the direct result of edema, while scrotal tongue is possibly inherited as a separate entity. The tongue findings are the least consistent manifestation of the syndrome, being present in only about 25 percent of cases. Scrotal tongue per se is a known irregular dominant hereditary anomaly occurring in 0.5 percent of the general population. That the entire Melkersson-Rosenthal syndrome itself represents a hereditary condition has recently gained more support. Carr's review uncovered seven patients whose relatives demonstrated some or all components of the syndrome.[8] The ultimate course of this symptom complex remains in dispute. While some have argued that the condition is self-limited, Hornstein states that once present the swelling never completely regresses. The edema which is eventually noncompressible may at times involve not only the upper lip but the lower lip, cheeks, eyelids, and forehead as well. This edema may tend to mask atrophy of the underlying muscles when paralysis of the facial nerve is present. In patients with hyposialia or asialia, atrophy of salivary glands, including the parotid, has been demonstrated microscopically.

Treatment

Nonsurgical treatment modalities have uniformly met with failure but offer colorful evidence of man's perseverance in attempting to cure that which he only incompletely understands. Anti-

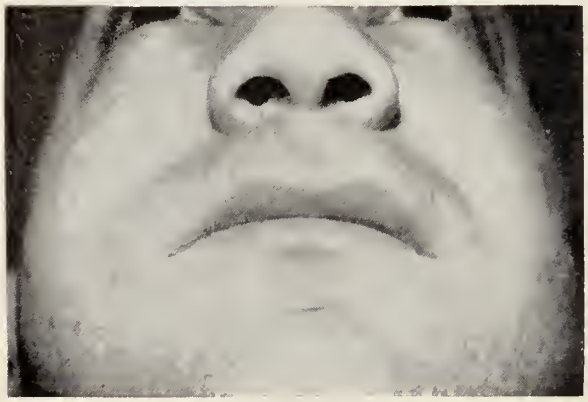




Fig. 3. Improved appearance following reduction cheiloplasty.

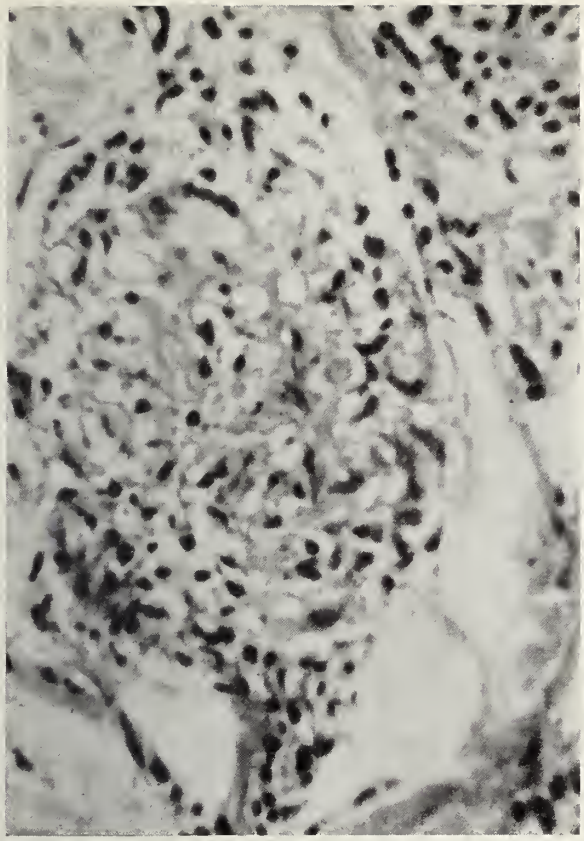


FIG. 4. Lip specimen showing sarcoid-like granuloma composed of histiocytes and multinucleated giant cells.

histamines, smallpox vaccine, Candida vaccine, steroids, and total dental extraction were used to no avail in the case presented by Klaus and Brunsting.[3] Other disappointing therapeutic modalities have included antituberculosis drugs, antibiotics, ACTH, vitamin D, Atabrine, ultrasound, x-ray, and injection of boiling water.[1]

Conclusion

It is recognized that the so-called classic triad of the Melkersson-Rosenthal syndrome, ie, facial edema, facial paralysis, and lingua plicata, was not found in the patient discussed here. Nonetheless, the patient undoubtedly represents some form of this syndrome which has been known for over a century. The surgery performed on this patient could hardly be construed as a cure of the underlying problem. Saberman and Tenta in their extensive review have argued that since the affliction is not serious "and only mildly deforming," neither medical nor surgical treatment need be given. The truth remains that cosmetic surgery of the partially paralyzed or edematous face can be of immeasurable value in dealing with this deforming condition of obscure etiology.

Summary

A case of the Melkersson-Rosenthal syndrome is presented illustrating a probable *formes fruste* of this strange symptom complex. Aesthetic surgery is proposed to aid these unfortunately afflicted patients.

Acknowledgment: The authors wish to thank Dr. Dale Havre for his assistance with the photomicrography.

Generic and Trade Name of Drug
Quinacrine—Atabrine (Winthrop Laboratories)

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Physician's Bookshelf

Prevention of Highway Injury — This hardback book contains the proceedings of a symposium held in honor of the University of Michigan's Sesquicentennial Celebration and sponsored by the University's Medical School and Highway Safety Research Institute. It is published by the Highway Safety Research Institute of the University of Michigan.

As indicated in the editorial preface to the book, the purpose of the symposium and the book are to give maximum exposure to potential preventive programs in the areas covered. It is an attempt to bring together in concise form latest developments in traffic safety and the latest thinking on the subject.

Order from: Publications Distribution Service, The University of Michigan, 615 East University, Ann Arbor, Mich. 48104; price $6.50.

Measuring Medical Education is the title of a book containing the tests and procedures of the National Board of Medical Examiners. Author is John P. Hubbard, M.D., president of the National Board. It is recommended by the publishers for medical students preparing to take the examinations and medical educators. It is published by Lea & Febiger, 600 Washington Square, Philadelphia, Pa. 19106; price $8.50.

Office Lab Evaluation

"The Ohio State Medical Association encourages all Ohio physicians with office laboratory facilities to participate in the Proficiency Evaluation Program being sponsored by The College of American Pathologists and The American Society of Internal Medicine."

That is the introductory paragraph of a letter sent to members of the Ohio State Medical Association recently by President P. John Robechek. His letter continues:

"We feel that this type of self evaluation is much better as a part of a voluntary program sponsored by medicine than it would be as a program controlled by any third party agency."

A pamphlet entitled, PEP, *A Proficiency Evaluation Program for the Physician's Office Laboratory,* was mailed with the letter to OSMA members. In the back of this pamphlet is an application form and instructions as to mailing. The deadline is February 15.

About 7,000 high school-age young people filled assignments as volunteers in the Veterans Administration's 165 hospitals in 1971, the VA reported.

Discussion of E.N.T. Case of the Month

(continued from p. 127)

This lesion, because of its resemblance to a frog's belly, has been aptly named ranula. These inclusion cysts are thought to be derived either from blockage of one of the sublingual or other minor salivary ducts located in the floor of the mouth or from cystic degeneration of a salivary gland parenchyma.

Diagnostically, a ranula may be confused with an epidermoid or dermoid cyst, which also may present as a soft swelling in the floor of the mouth. However, dermoids usually present in the midline, while ranula will be located chiefly in the lateral sulcus. Aspiration is also of value in evaluating a cystic lesion in the mouth. A ranula will produce a thick mucus, while epidermoid cysts are filled with desquamated sebaceous material.

The treatment for a symptomatic ranula is excision.



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the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences in their activity levels and estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

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the Ovulen phase

Most women* with a **balanced hormone profile and normal menses** do best on a middle-of-the-road pill that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts, feminine appearance, healthy skin and hair. Vagina cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slight progestogen dominance. It has an excellent record of patient acceptance.

Ovulen®

Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information see following page.



the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

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Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

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Each tablet contains: norethynodrel 2.5 mg./mestranol 0.1 mg.

Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.

for the 3 phases of Eve:

a family of O.C. products

Ovulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold; while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

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Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

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"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

". . . there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. ij tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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Professional Activities



Proceedings of The Council

Meeting of December 11-12, 1971

A REGULAR MEETING of The Council of the Ohio State Medical Association was held Saturday, December 11, and Sunday, December 12, 1971, at the Scot's Inn Motel and Restaurant, 4900 Sinclair Road, Columbus, Ohio. All members of the Council were present. Others attending the meeting were the following: Mr. James E. Pohlman, Columbus, OSMA legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, and Moore of the OSMA executive staff. Dr. R. L. Meiling, Columbus, chairman of the Ohio delegation to the American Medical Association, and Mr. Barney King, Columbus, representative of the Student American Medical Association, Ohio State University College of Medicine, attended the meeting on Saturday. Dr. Robert E. Howard, Cincinnati, chairman of the OSMA Ad Hoc Committee on Delivery of Health Care Systems, was present at the meeting on Sunday.

H.R. 7182 and Medical Advances Institute

The first item of business was a discussion of H.R. 7182 and Medical Advances Institute. Subsequent to the discussion, on **motion** by Dr. Lieber, seconded by Dr. McLaman and **carried,** the Council pledged reaffirmation of its position of vigorous and enthusiastic support of House Resolution 7182 (Devine-Betts, 92nd Congress), which provides for professional standards review organizations, and of Medical Advances Institute, the Ohio State Medical Association vehicle for making possible that professional standards review be done by physicians. A roll call was requested. The **motion passed** unanimously with all officers and councilors voting (15-0).

On **motion** by Dr. Becker, seconded by Dr. Fulton and **carried,** the Council voted to recommend to the Medical Advances Institute that that organization investigate through the Regional Medical Programs as a possible source of funding for the development of professional standards review organization programs.

Dr. Henry reported on his testimony before the House Ways and Means Committee, November 4, 1971, regarding House Resolution 7182. He announced that it was his hope that he be invited to testify before the executive session of the House Ways and Means Committee when PSRO legislation is being finalized.

Dr. Henry reported on the November 12, 1971 meeting of Medical Advances Institute and announced that the Professional Standards Review Council had been organized with the following physicians on the roster:

First District—Eugene Burns, M.D., Cincinnati, general surgery.

Second District—Robert Taylor, M.D., Dayton, surgery.

Third District—Dwight L. Becker, M.D., Lima, general practice.

Fourth District—Frederick C. Bowdle, M.D., Toledo, obstetrics-gynecology.

(Continued on Next Page)

Fifth District—William Trowbridge, M.D., Cleveland, neurosurgery. Alternate: Kenneth Clement, M.D., Cleveland, surgery.

Sixth District—Robert R. Clark, M.D., Akron, orthopedic surgery. Alternate: Arnold Schuring, M.D., Warren, ear.

Seventh District—John W. Metcalf, Jr., M.D., Steubenville, obstetrics-gynecology.

Eighth District—George Morrice, M.D., Newark, internal medicine.

Ninth District—Joseph P. Brady, M.D., Gallipolis, internal medicine.

Tenth District—Philip Taylor, M.D., Columbus, surgery. Alternate: William A. Millhon, M.D., Columbus, internist.

Eleventh District—John E. Rosso, M.D., Willard, general practice.

Osteopathic Association—W. D. Henceroth, D.O., Grove City.

Member-At-Large—Joseph L. Bilton, M.D., Cleveland Heights, general surgery; John J. Gaughan, M.D., Cleveland, radiology.

Dr. Henry also announced that the following will serve on the Professional Standards Review Specialty Panels:

Anesthesiology—Nicholas G. DePiero, M.D., Garfield Heights.

General Practice—J. R. Williams M.D., Toledo; James R. Williams, M.D., Niles, co-chairman.

Internist—William A. Millhon, M.D., Columbus.

Medical Education—Gordon Margolin, M.D., Cincinnati.

Ophthalmology—Robert O'Dair, M.D., Columbus.

Orthopedics—James G. Roberts, M.D., Akron.

Otolaryngology—Gabriel Marshak, M.D., Cincinnati.

Pediatrics—Homer Anderson, M.D., Columbus.

Physical Medicine—John L. Melvin, M.D., Columbus.

Plastic Surgery—H. William Porterfield, M.D., Columbus.

Psychiatry—John A. Whieldon, M.D., Columbus.

Surgery—Wesley Furste, M.D., Columbus.

Medical Advances Institute is awaiting recommendations from other specialties.

Minutes Approved

Minutes of the meeting held October 2-3, 1971 were approved by official action.

Reports by Councilors

The Councilors reported on various matters and activities of interest in their respective districts.

Membership

Statistics

The Executive Director reported on membership statistics as of November 24, 1971.

It was noted that there was a total gain of 125 members over the previous year, including a gain of 88 paid members.

Results of Survey

The Executive Director presented the results of a survey of other state medical associations regarding waiver of dues for members coming from other states during the membership year. The survey was referred to the Committee on Auditing and Appropriations for study.

County Members Not OSMA Members

The Membership Department brought to the attention of the Council the existence of "active members" of two county medical societies who had not yet been certified for membership in the Ohio State Medical Association. The Council requested that the names of these physicians be referred to the Councilors of the districts wherein this discrepancy has occurred.

The Ohio State Medical Journal

Mr. Moore reported on the operations of *The Ohio State Medical Journal* and the report was accepted for information.

Report of Auditing and Appropriations Committee

The Council convened in executive session for the report of the meeting of the Committee on Auditing and Appropriations, held on December 10, 1971, as presented by Dr. Oscar Clarke, chairman.

The following budget for 1972 was recommended to the Council:

Budget for 1972

The Ohio State Medical Journal (10,200 members @ $4.50)	$ 45,900.00
Executive Salaries	125,250.00
Executive Staff Expenses	17,000.00
Secretarial Administrative, Clerical, Military Advisory Chairman, Salaries	79,590.00
President: Expense $6,000; Honorarium $5,000	11,000.00
President-Elect: Expense $3,600; Honorarium $2,000	5,600.00
Secretary-Treasurer: Honorarium $2,000	2,000.00
Council Expense	16,500.00
AMA Delegate Alternate Expense (Per diem $35; Ground travel $20)	25,000.00
Committees:	
Ad Hoc Committee on Health Care Delivery Systems	1,500.00
Auditing and Appropriations	3,000.00
Cancer	350.00
Disaster Medical Care	500.00
Education (Commission on Education)	2,000.00
Environmental and Public Health	1,000.00
Eye Care	400.00
Governmental Medical Care Programs	1,500.00
Health Care of the Poor	1,000.00
Hospital Relations	750.00
Insurance	500.00
Judicial and Professional Relations	500.00
Laboratory Medicine	400.00
Liaison Committee to Nationwide Insurance Co.	300.00
Maternal Health	2,400.00
Medicine and Religion	250.00
Membership and Planning	5,000.00
Mental Health (Drug Abuse)	3,250.00
Nursing	300.00
Private Practice	750.00
Professional Standards Review Organization	5,000.00
Public Relations	400.00
Rehabilitation	250.00
Rural Health	1,750.00
School Health	5,000.00
Scientific Work	600.00
Workmen's Compensation	500.00
Annual Meeting	62,000.00
Car Lease	5,750.00
Conference of County Society Officers	2,500.00
Councilor District Conferences	5,000.00
Emergency Fund	2,500.00
Equipment Rental: Xerox, etc.	7,500.00
Family Practice Scholarships	4,000.00
Insurance and Bonding	9,000.00
Legal Expense	20,000.00
Library	400.00
OSMAgram	7,500.00
Postage	12,000.00
Professional Relations Activities	5,000.00
Public Relations Department:	
Information Materials	1,500.00
Miscellaneous Activities	5,000.00
Rent	31,142.00
Stationery, Printing and Supplies	9,000.00
Taxes: Payroll	9,500.00
Telephone and Telegraph	8,500.00
Depreciation	3,500.00
Furniture and Equipment	1,000.00
TOTAL BUDGETED FOR 1972	$579,282.00

A **motion** for the approval of the Auditing and Appropriations Committee report and of the 1972 budget **was carried.**

American Medical Association

Resolutions

Dr. Meiling reported on the clinical session of the American Medical Association held in New Orleans, November 28 to December 1.

He announced that one of the resolutions presented by the Ohio delegation, requesting equal opportunity for participation in the American Medical Association for females, **was adopted** as presented. He commented that there are 27,000 female physicians in the United States of whom 23,000 are members of the AMA. Only nine female physicians are on committees of the American Medical Association at this time and no elective offices are held by women physicians. Dr. Meiling said that 17 percent of medical school freshmen are women and by 1975 this percentage would advance to 25.

Dr. Meiling announced that the Ohio State Medical Association resolution, asking that educational or training programs based in hospitals be financed by local, state and federal programs instead of the patient's bill, was amended and adopted in the form of a request for a study of the situation to determine if it is feasible to indemnify such costs and to assign them to other sources than to patients. The action of the AMA House of Delegates requires that the study committee report periodically to the House on this matter beginning in June, 1972.

House Activities in AMA Program

The request of the Ohio delegation that a schedule of activities of the House of Delegates and reference committees be placed in the scientific program issued by the American Medical Association at the annual and clinical sessions was discussed by Dr. Meiling.

Long-Range Planning

Developments within the Council on Long-Range Planning and Development of the American Medical Association, which was established by a resolution from the Ohio State Medical Association, were discussed by Dr. Meiling, vice-chairman of the Council.

Minutes of Ohio Delegation

The minutes of a meeting of the Ohio delegation to the American Medical Association, held on October 22, 1971 at the Scot's Inn, Columbus, **were approved,** with the addition of Dr. Dwight L. Becker's name to those who were in attendance.

The Council authorized the President and President-elect to continue to investigate a possible

loose coalition of midwestern states for the purpose of the exchange of ideas.

Dr. Budd's Report

A report from Dr. John Budd on the World Medical Association meeting and the National Blue Shield meeting was accepted for information.

1972 Annual Meeting

A progress report on the 1972 Annual Meeting was presented by Mr. Campbell.

Speaker's Fee

The Council set a range of $1,500 to $2,000 as a speaker's fee in the event that Governor Reagan of California is obtained as a speaker. As alternate to Governor Reagan, the Council suggested the following in the order of preference: (1) Congressman Wilbur D. Mills, Arkansas; (2) Merlin K. DuVal, M.D., Washington, D.C.; (3) Congressman Donald G. Brotzman, Colorado; (4) Congressman Jerry L. Pettis, California; (5) Congressman Paul G. Rogers, Florida.

1974 Meeting Place

On motion by Dr. Fulton, seconded by Dr. Fishman and carried, the Council reaffirmed a previous decision to hold the 1974 annual meeting in Cleveland, Ohio.

Resolutions

The Council received for information House of Delegates resolutions from Delaware and Ross Counties.

Conference of County Officers

It was the decision of the Council that county medical society presidents, presidents-elect, executive secretaries and other officers be invited and encouraged to attend a meeting on Medical Advances Institute and H.R. 7182 on Sunday, January 30, in Columbus, the day after the called meeting of the Professional Advisory Review Council of Medical Advances Institute.

District Meetings on H.R. 7182 and MAI

The Council voted to authorize councilor district dinner meetings for the discussion of H.R. 7182 and Medical Advances Institute within the next 60 to 90 days. These meetings are in addition to the traditional pre-annual meeting caucuses of officers and delegates held for consideration of resolutions and candidates. Each Councilor was requested to send the date, time and place of his meeting to the OSMA headquarters office so that plans can be coordinated.

Constitutions and Bylaws

Cuyahoga County

The Council voted to waive several minor corrective amendment suggestions in the Constitution and Bylaws of the Academy of Medicine of Cleveland until the next revision, thereby giving final approval to the constitution and bylaws as submitted.

Madison County

Amendments to the Constitution and Bylaws of the Madison County Medical Society were approved, subject to certification by the county that proper procedures were followed in adopting the amendments.

Lorain County

Amendments to the Lorain County Constitution and Bylaws were approved as submitted.

Clermont County

Amendments to the Clermont County Constitution and Bylaws were approved, subject to certification by the county society that proper procedures were followed in adopting the amendments.

Licking County

The Council delayed the approval of the revised Constitution and Bylaws submitted by the Licking County Medical Society until the OSMA legal counsel consults with the society with regard to the rule making authority proposed under Item 10 in the letter received from the society president.

Amendment to OSMA Bylaws

The Council voted to submit to the House of Delegates a resolution to amend Section 5, Chapter 1, to change from five years to six years the period of time granted a non-citizen to acquire United States citizenship.

Subsequent to the adoption of such resolution by the House of Delegates, the Council voted to suggest to all county medical societies that they also change the requirements in their bylaws in Section 5, Chapter 1 for the period granted to acquire citizenship from five to six years.

Ohio Medical Indemnity, Inc.

The Ohio Medical Indemnity Liaison Committee report was presented by Drs. Fulton, Ivins and Wells.

With regard to a request for an opinion from Ohio Medical Indemnity, Inc., concerning a pro-

posal for participation in a health maintenance organization contemplated by a physicians' group in Marion, Ohio, OMI was referred to Council's interpretation of OSMA House of Delegates Resolution No. 14-71, as adopted October 2-3, 1971. In view of Resolution No. 14-71, the Council recommended against OMI participation.

Report of Legal Counsel

Mr. James E. Pohlman, OSMA legal counsel, reported on the following matters:

1. A meeting of Practicing Law Institute, held October 22-23, 1971 in New York.

2. A recent opinion of the Attorney General of California on hospitals and the practice of medicine.

3. A progress report on the defense of a lawsuit by a group of chiropractors against the American Medical Association, Ohio State Medical Board and the Ohio State Medical Association.

4. A progress report on the development of a video tape testimony proposal of Chief Justice C. Wm. O'Neill of the Ohio Supreme Court.

Federal Legislation

The following report was given by Mr. Charles W. Edgar regarding federal legislation:

Cancer

Mr. Edgar reported that the legislation to appropriate considerable sums to launch a crash program to seek a cancer cure had been signed by the President. The program will be administered by the National Institutes of Health.

Child Care

Mr. Edgar reported that President Nixon had vetoed legislation which, among other items, would have provided a comprehensive child care program, including full medical-health care services, for working parents.

National Health Care System

Mr. Edgar reported that almost all Washington observers predict some type of national health care legislation in 1972, that it will be a Presidential campaign issue, that all political interests probably will attempt to take credit for it, and that the looming passage of such legislation makes passage of H.R. 7182 imperative.

State Legislation

Case WRU School of Medicine

The Executive Director presented a letter from Mr. Sam Whitman, Associate Dean, Case Western Reserve University School of Medicine, dated November 3, 1971, expressing appreciation to the OSMA for Mr. Edgar's assistance to him in furthering the Western Reserve University School of Medicine legislative program in the Ohio General Assembly. The Council expressed its appreciation to Associate Dean Whitman for his kind comments.

Senate Bill 450 (Ocasek)

Mr. Clinger presented Senate Bill 450 (Ocasek), a measure which proposes to delete smallpox from the immunization required by law prior to school admissions. This concept has the approval of Dr. John Cashman, Ohio Director of Health. The Council voted active support.

Proficiency Evaluation Program Approved

Dr. Thomas presented information with regard to a proficiency evaluation program for the physician's office laboratory, co-sponsored by the College of American Pathologists and the American Society of Internal Medicine.

The Council granted authority to the Committee on Laboratory Medicine of the Ohio State Medical Association for the mailing of a brochure on the program to the physicians of Ohio, with an appropriate letter from President Robechek. It was specified that mailing arrangements would be subject to clearance with the chairman of the Auditing and Appropriations Committee.

Committee Reports

Committee on Health Care of the Poor

The minutes of the meeting of the Committee on Health Care of the Poor, September 29, 1971, were presented by Mr. Gillen. It was noted that committee status was granted to this former subcommittee, with the adoption of the 1972 budget report. The Council authorized the President to appoint a member of the Committee on Private Practice to act in liaison to the Committee on Health Care for the Poor.

The approval of the minutes included authorization for expansion of representation, thereon, to include both urban and rural physicians from the western half of Ohio, and the chairman of the Committee on Rural Health.

Goal No. 1 of the Mid-Term Goals of the Committee was amended to read as follows: 1. Establish mechanism for scheduled hearings at which the poor and representatives of agencies and organizations concerned with the poor can express their views.

Goal No. 5 of the Mid-Term Goals was amended to read as follows: 5. Assist in the

development of health care delivery models for the poor and disseminate information on selected model programs for use by physicians, other health professionals, and the public, which are consistent with the policies of the House of Delegates of the Ohio State Medical Association.

The report, as a whole, as amended, **was approved.**

Committee on Private Practice

The minutes of the meeting of the Committee on Private Practice, on September 29, 1971, were presented by Dr. Lieber. The Council amended the minutes by inserting quotes around paragraphs 1 and 2 at the top of page 4. The minutes were accepted as amended.

Committee on Workmen's Compensation

The minutes of the Committee on Workmen's Compensation meeting of October 9, 1971, were presented by Mr. Campbell. Approval of the report included authorization of the Committee to publicize in the OSMAgram and *The Ohio State Medical Journal,* the success of the Bureau of Workmen's Compensation-OSMA usual, customary and reasonable fee program, since its inception in October, 1965. The report **was approved** as presented.

Commission on Medical Education

The minutes of the October 20, 1971, meeting of the Commission on Medical Education were presented by Mr. Edgar. The Council expressed its appreciation to Dr. Glidden Brooks for his leadership as the Commission's first chairman, authorized the President to communicate with Dr. Brooks commending him on behalf of the Council for his work with the Medical School of Ohio at Toledo and with the Commission, and voted to award to him a special plaque during the 1972 Annual Meeting.

The Council agreed with the committee's suggestion to delay action on a recommendation for endorsement of the training program for Directors of Medical Education, which is to be sponsored and conducted by the Ohio State University Regional Medical Program.

Council received a message from Dr. Thomas E. Rardin, thanking the Ohio State Medical Association for its work in the establishment of the American Board of Family Practice.

The Council ratified the appointment of Dr. Howard S. Madigan as a member of the Commission.

The minutes **were approved.**

Committee on Fee Review

Minutes of the November 10 and December 8 meetings of the Committee on Fee Review were presented by Dr. Ivins, and the report as a whole **was accepted.**

Committee on Nursing

The minutes of the October 27 meeting of the Committee on Nursing were presented by Mr. Gillen.

The Council disapproved a suggestion of the committee for a Joint Commission, in conjunction with the Ohio Nurses Association and the Ohio Hospital Association, to review the scope of personnel in the health care delivery system, since such is not within the jurisdiction of the committee and has been previously assigned to the Commission on Medical Education of the Ohio State Medical Association.

The Council agreed with a section of the report of the committee, which declared not acceptable the proposed licensure of geriatric nurses.

The minutes **were accepted,** as amended.

Ohio Committee for Voluntary Health Planning

A report of the November 10 meeting of the Ohio Committee for Voluntary Health Planning was presented by Dr. Fishman.

The Council voted to lend OSMA support to the principle of the Ohio Voluntary Health Planning Commission proposal for legislation in the Ohio General Assembly, which would make it possible for the State of Ohio to provide up to 25 percent matching fund financing under Public Law 89-749 for comprehensive health planning, "B" agencies.

Committee on Environmental and Public Health

The minutes of the November 17, 1971 meeting of the Committee on Environmental and Public Health were presented by Mr. Gillen.

The Council modified the minutes of the committee to provide for an educational program to members regarding the Occupational Safety and Health Act of 1970, through an article in *The Journal* with a paragraph in the OSMAgram directing attention to *The Journal* article. It was the expression of the Council that such article have advance approval of legal counsel.

The minutes **were approved,** as amended.

Sports Medicine

Mr. Clinger reported on developments in the field of sports medicine and announced that a Postgraduate Educational Program for Physicians will be sponsored by the Committee on Sports Medicine and allied organizations during the summer.

The report **was approved.**

SIC Project

A communication from Project SIC, "Survey of Innovative Changes in Health Care," signed by Charles E. Lewis, M.D., Project Director and comments from Nicholas M. Griffin, Secretary to the AMA Council on Health Manpower, were received by the Council. It was the expression of Council that requests for assistance from SIC be considered on a specific basis as they arise.

Correspondence on Medicare

A communication from Dr. J. R. Sheets, Portsmouth, President of the Scioto County Medical Society, regarding his correspondence with Dr. Paul Metzger, Vice President of Nationwide Insurance Company, was received for information.

Coroners' System Upheld

With regard to correspondence from the National Municipal League of New York, concerning the establishment of a medical examiner system in Ohio, the Council expressed as OSMA policy its confidence in the present coroners' system in this state.

Survey of Non-Physicians as Assistants

A communication from the Ohio Regional Medical Programs, concerning a proposed survey on the use of non-physicians as assistants, relayed to the Council by Dr. Robert N. Smith, a member of the Advisory Committee to the Ohio Regional Medical Programs, was referred to the Commission on Medical Education.

UCR Policy Reaffirmed

Dr. Press presented to the Council a communication to him from the State of Ohio Rehabilitation Services Commission, with regard to the establishment of a fee schedule. The Council reaffirmed as Ohio State Medical Association policy, the principle of the usual, customary and reasonable fee, with provisions of review mechanisms by county medical societies and the State Medical Association with regard to fees for services rendered.

Next Council Meeting—February 12-13

February 12-13 was established for the next meeting date.

Adjourned.

ATTEST: Hart F. Page *Executive Director*



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Admin. Director

HERBERT A. SIHLER, Jr.
President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

Deadline for Submission of Resolutions to OSMA Office is March 9

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1972 Annual Meeting should be guided by the following requirements of the Bylaws:

Resolutions, regardless of whether they have been submitted in advance must be introduced at the first session of the House of Delegates, Monday morning, May 8, at the Cincinnati Exposition Center.

To be eligible for presentation, a resolution must be filed with the Executive Director of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely not later than March 9. This requirement may be waived by a two-thirds majority of the House of Delegates.

Copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

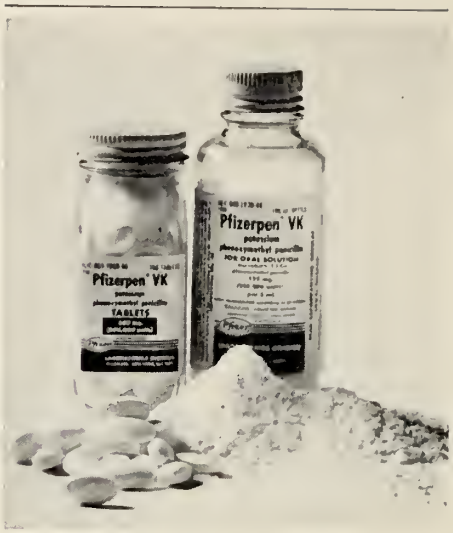
Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 8-11.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 9.

The Part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."

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800,000 units: bottles of 100.

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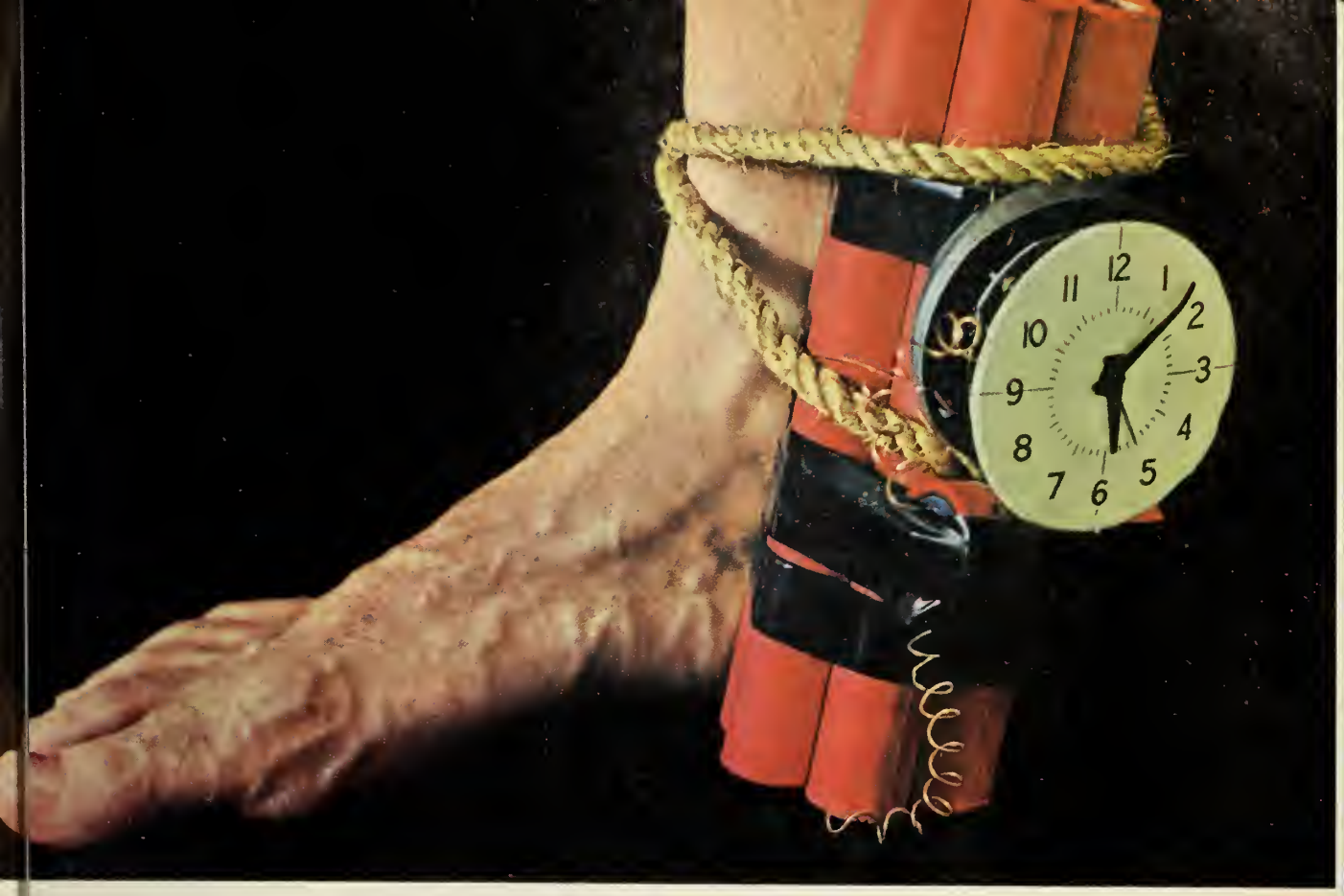
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nportant Note: This drug is not a simple analgesic. o not administer casually. Carefully evaluate patients efore starting treatment and keep them under close persion. Obtain a detailed history, and complete ysical and laboratory examination (complete emogram, urinalysis, etc.) before prescribing and at equent intervals thereafter. Carefully select patients, oid: those responsive to routine measures, contraindicated patients or those who cannot be observed equently. Warn patients not to exceed recommended osage. Short-term relief of severe symptoms with e smallest possible dosage is the goal of therapy. osage should be taken with meals or a full glass of ilk. Patients should discontinue the drug and report mediately any sign of: fever, sore throat, oral sion (symptoms of blood dyscrasia); dyspepsia, igastric pain, symptoms of anemia, black or tarry ools or other evidence of intestinal ulceration or emorrhage, skin reactions, significant weight gain or lema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict eatment periods to one week in patients over sixty. *dications:* Acute gouty arthritis, rheumatoid arthritis, eumatoid spondylitis.

ntraindications: Children 14 years or less; senile atients; history or symptoms of G.I. inflammation or ceration including severe, recurrent or persistent speptia; history or presence of drug allergy; blood scrasias; renal, hepatic or cardiac dysfunction; pertension; thyroid disease; systemic edema; omatosis and salivary gland enlargement due to the ug; polymyalgia rheumatica and temporal arteritis; atients receiving other potent chemotherapeutic gents or long-term anticoagulant therapy.

arnings: Age, weight, dosage, duration of therapy, istence of concomitant diseases, and concurrent herapy affect incidence of toxic reactions. Carefully instruct and observe the individual atients especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially predictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

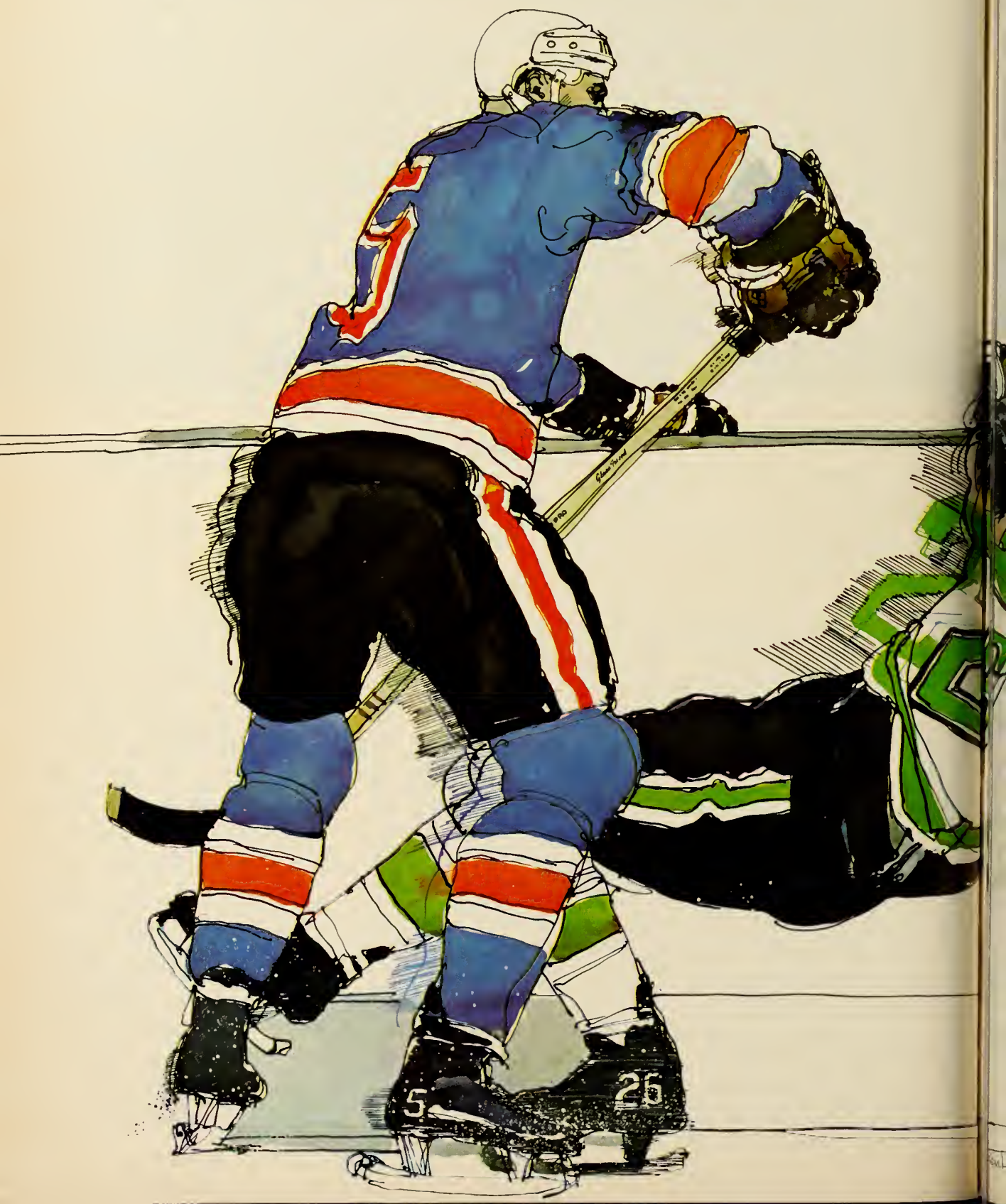
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Summary of Actions of the AMA House of Delegates

THE OHIO DELEGATION to the American Medical Association introduced two resolutions at the November 27-December 1, 1971 AMA House of Delegates Clinical Session held in New Orleans. The two resolutions were titled "Relief of Hospitalized Patients' Financial Responsibility for Hospital Based Educational and Training Programs," and "The Role of Female Physicians in 'Policy Making' at Local, State, and AMA Organizations."

The first resolution called for the House of Delegates to direct the appropriate AMA agencies to study and report suitable recommendations or proposals as to the question of providing, at the earliest possible time, relief of patients being involuntarily assessed the cost of hospital based educational and training programs involving physicians, post M.D. candidates, nurses, paramedical and administrative personnel. Two similar resolutions were also introduced.

The House adopted a substitute resolution as follows:

"RESOLVED, that the Board of Trustees be urged to assign to appropriate councils and committees the responsibility to conduct a detailed study of the costs of hospital services to identify (1) the multiple factors involved; (2) the elements that have the greatest impact on the rise in hospital costs; (3) the various cost factors attributable to hospital-based medical and allied health education programs; (4) the alternative mechanisms to finance the costs of such educational programs including the possibility of reducing or eliminating charges to patients that are attributable to such programs; (5) the degree of impact, if any, that federally funded health programs have on these hospital costs."

The resolution called for the study to be conducted in consultation with the American Hospital Association, private and governmental payment agencies, and representatives of the public. Periodic progress reports, to be submitted at each session of the House of Delegates until completion of the study, also were requested.

The other Ohio resolution which emphasized the rights of female physicians with respect to policy making positions and contributions to the structure and activities of medical organizations at all levels was approved by the House as follows:

"RESOLVED, That the AMA recognize the high professional and civil qualifications of many female physicians and as a matter of policy encourage their election and appointment to positions of importance within and outside the Association, and be it further

"RESOLVED, That the American Medical Association urge state and local medical societies to similarly recognize the important role female physicians can play in their organizational structure; and be it further

"RESOLVED, That more efforts be made to recruit the increasing numbers of female physicians into the AMA with demonstrable assurances that a physician shall be judged on merit and not on his or her sex in the future policy making councils of American medicine."

The House had before it for consideration at this session 36 reports and 72 resolutions. A summary of some of the actions taken is reported in the following resume.

The House adopted a measure which approved "creation of a special section for medical students and a section for interns and residents." The long-heard appeal of students and younger physicians for a voting voice in the AMA was thus answered.

President's Address

AMA President Wesley W. Hall, saying, "our House of Medicine is sorely in need of some major repairs," repeated his call for a Constitutional Convention, or other appropriate procedure, for a basic review of organizational structure and programs. He first suggested such a convention upon his inauguration last June.

Dr. Hall also called for closer liaison with specialty societies; suggested the AMA should sponsor only national and international congresses on general subjects, rather than its traditional meetings, and said it may be time to consider reorganizing the association as a "for profit" corporation or service corporation.

Dr. Hall's address and a resolution which also called for organizational review, were studied and discussed in reference committee. The committee

also studied two reports dealing with the question of a Constitutional Convention, from the Councils on Constitution and Bylaws, and Long Range Planning and Development, both of which recommended against holding a Constitutional Convention.

Many of the problems faced by medicine come from social unrest and are common to all society, the committee said. It said Dr. Hall, "in his tireless efforts in appearances throughout the country, has seen this unrest and is to be commended for bringing this to the attention of the House of Delegates."

The House accepted the committee's recommendation to refer Dr. Hall's remarks and Resolution 50 to the Council on Long Range Planning and Development. But it also called for specific procedures to be instituted by the Council.

An amendment instructed the Council to hold open hearings for the membership in San Francisco in June, 1972, and in Cincinnati in November, 1972, and provide the House with progress reports and a summary report on its recommendations and findings in June, 1973, in New York.

Vice-President

There was overwhelming support to give the vice-president of the AMA voting privileges on the Board of Trustees, and the measure was quickly adopted by the House. Presently, the vice-president attends Board meetings, with the right of discussion but no vote.

Non-Member Participation

The House amended the Bylaws to permit physicians who are not members of the AMA to participate in AMA scientific programs as "invited guests." The feeling was that programs should be available to all members of the profession.

Dues for Interns and Residents

The House established annual dues of $20 for interns and residents as members of the AMA. The amount was calculated "solely to cover some of the costs of the benefits of membership," such as receiving AMA publications. Interns and residents currently may join the AMA in two ways: Through active membership in a state association or, where there are no provisions for such membership, by direct application to the AMA. In either case, they must pay the $20 AMA dues.

Physicians' Assistants

Several major actions were taken in regard to the rapidly developing field of physicians' assistants.

The House directed that the AMA, through its Council on Health Manpower, "assume a leadership role in developing and sponsoring a national program for certification of the assistant to the primary care physician, who functions at the highest level of responsibility described by the National Academy of Sciences as a 'Type A' assistant."

Delegates also adopted a report of the Council on Medical Education, outlining essential requirements for AMA approval of educational programs for such assistants.

The House directed the Board of Trustees to develop guidelines on compensation of physicians for the services of their assistants, and to report back to the House next June.

Miscellaneous

Immediate action to improve the quality of emergency medical services in the United States was urged in a Board of Trustees report adopted by the House. The report said:

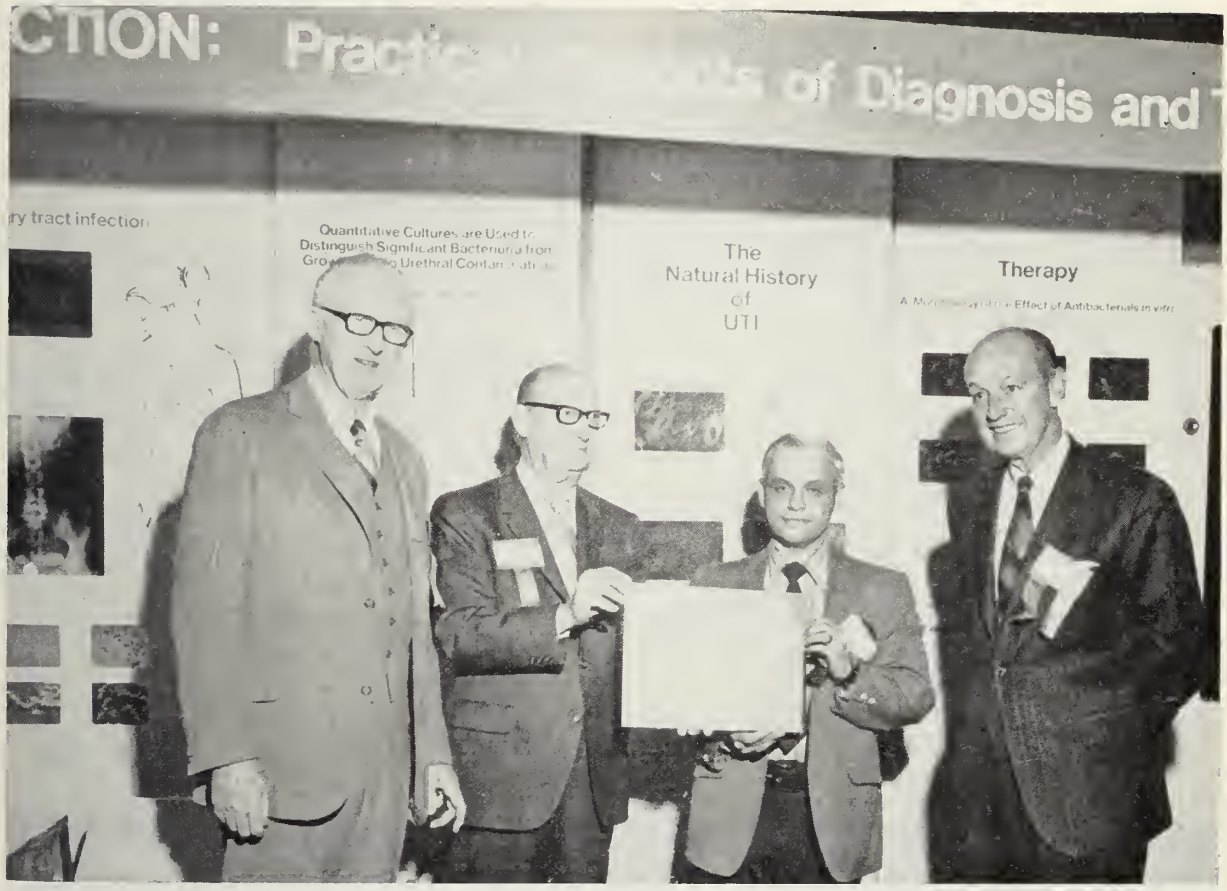
"Those medical societies that have not already done so are urged to establish councils on emergency medical services or to assign that subject area to an appropriate existing council, whose responsibility should include developing action-pro-

Ohio Physician Is Installed as President of AMWA



Highlight of the American Medical Women's Association's Annual Meeting was installation of Dr. Frances Keller Harding, Columbus, as President. The meeting was held in New Orleans immediately following the Clinical Convention of the American Medical Association. Dr. Harding, a practicing physician in Columbus, has been a leader in the AMWA for a number of years and was named President-Elect at the 1970 Annual Meeting.

Ohio Exhibit Team Wins Top Award



Top honors for a Scientific Exhibit at the AMA Clinical Convention in New Orleans came to an Ohio team. Winner of the Thomas G. Hull Award was presented to sponsors of the exhibit entitled, "Urinary Tract Infection: Practical Aspects of Diagnosis and Treatment," presented by Albert S. Klainer, M.D., Robert J. Fass, M.D., and Robert L. Perkins, M.D., of Ohio State University College of Medicine. Dr. Klainer, second from right above, is shown receiving the award as one of the sponsors. Presenting the award to Dr. Klainer are members of the AMA Council on Scientific Assembly — from left, John B. Dillon, M.D., Charles D. Bussey, M.D., chairman, and Dr. Robert H. Barter.

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grams in emergency medical services to meet their area's needs and maintaining liaison with groups at all levels of organized medicine concerned with emergency medical services."

Small communities without necessary resources to develop their own systems "should consider linking together with surrounding communities to form a regional system." Skilled personnel and high quality equipment and facilities should be provided, the report said, and the medical profession should see to it that quality of service is periodically evaluated. The report also recommended a single agency at the federal level with responsibility for all governmental efforts to improve emergency medical services.

A revised statement on the scope, objectives and functions of occupational health programs also was adopted by the House. The statement, among other things, said "some employes on occasion may find it impossible to locate or to obtain the services of a personal physician or health service. In such circumstances, limited to where treatment is otherwise unavailable, the occupational physician may undertake additional and continuing treatment of an employe's nonoccupational condition if requested to do so by the employe or his family."

The statement added that if such services become ongoing within the occupational health program, approval of the employer should be obtained. "In order to assure high quality medical

care, consideration and approval by the local medical society in developing such projects, including the methods of payment for services, is urged."

The House adopted a study on Community Health Delivery Programs and urged it be given wide distribution. The study, by a task force of the Committee on Community Health Care, described funding, scope of operations and staffing of 30 programs around the nation.

Physicians should be active, the report recommended, in a number of areas including: participating in planning and operation of community health programs; using all means at their disposal to ensure that all people are afforded equal access to adequate medical and health care; supporting campaigns against factors harmful to health such as lead poisoning, drug abuse and poor housing; and supporting health education programs in schools, homes and the mass media. The federal government should be urged to consolidate all federal health programs under one department and to provide long-range approval and multiple-year funding — rather than annual funding — to help retain top staff, the report said.

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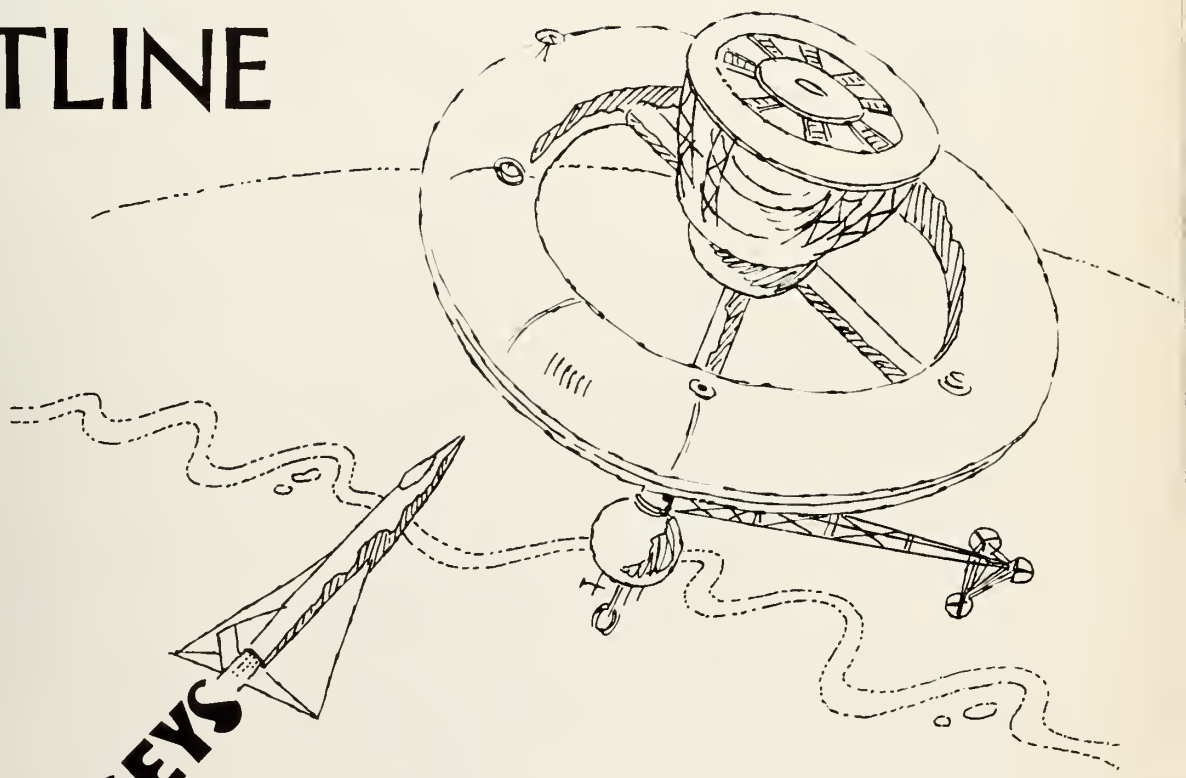
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OSMA
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OUTLINE



EDICAL ODYSSEYS
1995

WEEK OF MAY 7th 1972

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CINCINNATI INN

Important Information Regarding 1972 OSMA Annual Meeting

EFFORTS HAVE BEEN MADE to shorten the length of time that the physician needs to be away from his office this year to attend the business sessions of the OSMA House of Delegates. This will be of particular interest to all Delegates, Alternate Delegates, officers, official guests, etc. Please note the change in timing of District Caucus meetings, Registration of Delegates and Alternates, First Session of the House of Delegates, Reference Committee Hearings and the Final Session of the House of Delegates. Plan ahead in your office scheduling, appointments, etc. The Committee on Scientific Work and The Council of the Ohio State Medical Association are in hopes that the new format will be of assistance to *You,* the members of the Association, who are what makes the Annual Meeting a successful scientific conclave. *Please note the district caucus meetings will be held at the Terrace Hilton Hotel* even though the headquarters hotel is Stouffer's Cincinnati Inn.

SUNDAY, MAY 7

Evening

7:00 P.M.	Councilor District Caucus Meetings	*Terrace Hilton Hotel*
	District No. 1—Dr. Paul Ivins	Parlor Room 1926
	District No. 2—Dr. James Tye	Parlor Room 1914
	District No. 3—Dr. Dwight Becker	Parlor Room 1918
	District No. 4—Dr. George Bates	Parlor Room 1908
	District No. 5—Dr. David Fishman	Parlor Room 1923
	District No. 6—Dr. Maurice Lieber	Parlor Room 1905
	District No. 7—Dr. Sanford Press	Parlor Room 1001
	District No. 8—Dr. William Wells	Parlor Room 1002
	District No. 9—Dr. Oscar Clarke	Parlor Room 1035
	District No. 10—Dr. James McLarnan	Parlor Room 1909
	District No. 11—Dr. Robert Thomas	Parlor Room 1922

MONDAY, MAY 8

Morning

7:30 A.M.	Breakfast, Delegates, Alternates, OSMA Council and Official Guests	Bronze Room, Second Floor Stouffer's Cincinnati Inn
7:30 -9:00 A.M.	Registration of Delegates, Alternates, OSMA Council and Official Guests	Upper Lobby, Second Floor Cincinnati Exposition Center

9:00 A.M.	First Business Session, OSMA House of Delegates	Room 209, Second Floor Cincinnati Exposition Center

NOTE: The House of Delegates floor will be divided into two sections, the voting section and non-voting section.

The voting section will be divided into districts, and only delegates or alternate delegates properly certified in place of an absent delegate will be seated in the voting section of his district. All other alternate delegates, past presidents, SAMA delegates, executive secretaries and guests will be seated together in another section.

This plan has been adopted in an effort to expedite the counting of ballots from the official voting delegation.

Noon

12:00 NOON	Buffet Luncheon, Delegates, Alternates, OSMA Council and Official Guests	Bronze Room, Second Floor Stouffer's Cincinnati Inn

Afternoon

1:30 P.M.	Meetings of Reference Committees	
	Res. Committee No. 1	Room 211, Second Floor Cincinnati Exposition Center
	Res. Committee No. 2	Room 213, Second Floor Cincinnati Exposition Center
	Res. Committee No. 3	Room 217, Second Floor Cincinnati Exposition Center
	Committee on President's Address	Room 221, Second Floor Cincinnati Exposition Center
	Committee on Nominations	Room 223, Second Floor Cincinnati Exposition Center

THURSDAY, MAY 11

Morning

7:30 A.M.	Breakfast, Delegates, Alternates, OSMA Council and Official Guests	Bronze Room, Second Floor Stouffer's Cincinnati Inn
7:30-9:00 A.M.	Registration of Delegates, Alternates, OSMA Council and Official Guests	Upper Lobby, Second Floor Cincinnati Exposition Center
9:00 A.M.	Final Business Session OSMA House of Delegates	Room 209, Second Floor Cincinnati Exposition Center

1972 OSMA ANNUAL MEETING SCHEDULE

STOUFFER'S CINCINNATI INN
(Headquarters Hotel)

CINCINNATI EXPOSITION CENTER
(Scientific Sessions and Exhibits)

MONDAY, MAY 8

See previous two pages for events relating to House of Delegates

6:00 P.M.	Party given for VIP Women	Stouffer's Cincinnati Inn

TUESDAY, MAY 9

8:30 A.M.	Breakfast, Ohio Committee on Trauma, A.C.S.	Stouffer's Cincinnati Inn
8:30 A.M.	General and Advance Registration Opens	Cincinnati Exposition Center
9:00 A.M.	Exhibits Open	Cincinnati Exposition Center
9:30-10:15 A.M.	Coronary Artery Disease Scientific Systemic Program	Cincinnati Exposition Center
10:00 A.M.	Section on Plastic Surgery	Cincinnati Exposition Center
10:00 A.M.	Business Meeting, Ohio Committee on Trauma, A.C.S.	Stouffer's Cincinnati Inn
10:15-10:45 A.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
11:00 A.M.	Opening Session—Ohio Health Commissioner's Institute	Cincinnati Exposition Center
10:45-11:30 A.M.	Continuation of Scientific Systemic Program	Cincinnati Exposition Center
1:30 P.M.	Program sponsored by the Ohio Committee on Trauma, A.C.S. Panel Program "What's New in Emergency Care?"	Cincinnati Exposition Center
2:00-2:45 P.M.	Continuation of Scientific Systemic Program	Cincinnati Exposition Center
2:45-3:15 P.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
3:15-4:00 P.M.	Continuation of Scientific Systemic Program	Cincinnati Exposition Center
4:30 P.M.	Close Exhibits for Tuesday	Cincinnati Exposition Center

ANNUAL MEETING SCHEDULE (Continued)

TUESDAY, MAY 9 (Continued)

5:00-6:00 P.M.	Reception for Exhibitors Technical, Scientific and Health Education	Stouffer's Cincinnati Inn
6:00 P.M.	Social Hour—Ohio Health Commissioners	
7:00 P.M.	Banquet—Ohio Health Commissioners	

WEDNESDAY, MAY 10

8:00 A.M.	Breakfast, Ohio Society of Thoracic Surgeons	Stouffer's Cincinnati Inn
8:00 A.M.	Board of Governors, Ohio Ophthalmological Society	Stouffer's Cincinnati Inn
8:30 A.M.	General and Advance Registration Opens	Cincinnati Exposition Center
9:00 A.M.	Health Commissioners Institute	Cincinnati Exposition Center
9:00 A.M.	CURBSTONE CONSULTATIONS "Know Your State Medical Board and Its Activities" Discussant Leader: Mr. William J. Lee, Columbus "Ob Emergencies" Discussant Leader: Anthony J. Ruppersberg, M.D., Columbus "What's Going On In Medicine & Religion?" Discussant Leader: Donald J. Vincent, M.D., Columbus	Cincinnati Exposition Center
9:00 A.M.	A Clinicopathologic Symposium "Calcium—Metabolism-Measurement and Maladies" A two day Symposium Sponsored by the College of American Pathologists (CAP) and the Ohio Society of Pathologists in cooperation with the Section on Pathology. Also a Regional Meeting of the CAP and an event in the Year of Pathology, 1972.	Cincinnati Exposition Center
9:00 A.M.	Section on Sports Medicine and Joint Advisory Committee on Sports Medicine of Ohio State Medical Association and the Ohio High School Athletic Association Scientific Program.	Cincinnati Exposition Center

ANNUAL MEETING SCHEDULE (Continued)

WEDNESDAY, MAY 10 (Continued)		
9:00 A.M.	Combined Meeting Ohio Society of Thoracic Surgeons and American College of Chest Physicians	Cincinnati Exposition Center
9:00 A.M.	Section on Ear, Nose and Throat; and the Ohio Society of Ear, Nose and Throat	Cincinnati Exposition Center
9:30 A.M.	Socio-Economic Program cosponsored by OSMA and Ohio Society of Internal Medicine and OSMA Section on Internal Medicine	Cincinnati Exposition Center
10:00 A.M.	Ohio Ophthalmological Society Annual Business Meeting	Cincinnati Exposition Center
10:15-10:45 A.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
10:45-11:30 A.M.	Continuation of Socio-Economic Program	Cincinnati Exposition Center
11:30 A.M.	OMPAC LUNCHEON Speaker: Mr. Robert D. Novak Washington Columnist & Political Analyst Subject: "Politics 1972"	Room 210, Second Floor Cincinnati Exposition Center
12:00 NOON	Luncheon American College of Chest Physicians	Stouffer's Cincinnati Inn
12:00 NOON	Luncheon Section on Sports Medicine	Stouffer's Cincinnati Inn
12:00 NOON	Luncheon Section on Rheumatology	Stouffer's Cincinnati Inn
12:00 NOON	Luncheon Ear, Nose and Throat Society and Section	Stouffer's Cincinnati Inn
12:00 NOON	Luncheon Ohio Ophthalmological Society	Stouffer's Cincinnati Inn
1:30 P.M.	Combined meeting Ohio Society of Thoracic Surgeons and American College of Chest Physicians	Cincinnati Exposition Center
1:30 P.M.	Health Commissioners Institute	Cincinnati Exposition Center
2:00 P.M.	Section on Ear, Nose and Throat and Specialty Society	Cincinnati Exposition Center

ANNUAL MEETING SCHEDULE (Continued)

WEDNESDAY, MAY 10 (Continued)		
2:00 P.M.	Section on Rheumatology followed by Business Meeting	Cincinnati Exposition Center
2:00 P.M.	Section on Directors of Medical Education	Cincinnati Exposition Center
2:00-2:45 P.M.	Continuation of Socio-Economic Program cosponsored by OSMA and Ohio Society of Internal Medicine and OSMA Section on Internal Medicine	Cincinnati Exposition Center
2:45-3:15 P.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
3:15-4:00 P.M.	Continuation of Socio-Economic Program	Cincinnati Exposition Center
3:00 P.M.	Section on Ophthalmology and the Ohio Ophthalmological Society	Cincinnati Exposition Center
3:00 P.M.	Section on Colon & Rectal Diseases	Cincinnati Exposition Center
6:00 P.M.	Ohio Psychiatric Association Council Dinner	Stouffer's Cincinnati Inn
7:00 P.M.	Ohio Psychiatric Association Council Meeting	Stouffer's Cincinnati Inn
7:00 P.M.	OSMA SOCIAL FUNCTION "Riverboat Odysseys: 1895" Buffet Dinner, Open Bar entertainment and cruise down the Ohio River in large party boat all for the price of $12.00 per person	At the Foot of Broadway (Bus transportation will be furnished from Stouffer's Cincinnati Inn
THURSDAY, MAY 11		
7:30 A.M.	Breakfast, Ohio Psychiatric Association Research & Education Foundation	Stouffer's Cincinnati Inn
7:30 A.M.	Breakfast, Delegates, Alternates, OSMA Council and Official Guests	Bronze Room, Second Floor Stouffer's Cincinnati Inn
7:30-9:00 A.M.	Registration of Delegates, Alternates, OSMA Council and Official Guests	Upper Lobby, Second Floor Cincinnati Exposition Center
8:30 A.M.	General and Advance Registration	Cincinnati Exposition Center
9:00 A.M.	Final Session—Business Meeting OSMA House of Delegates	Room 209, Second Floor Cincinnati Exposition Center

ANNUAL MEETING SCHEDULE (Continued)

THURSDAY, MAY 11 (Continued)		
9:00-11:00 A.M.	Workshop sponsored by the Section on Orthopaedic Surgery & Ohio Society of Orthopaedic Surgeons	Cincinnati Exposition Center
9:00 A.M.	Exhibits Open	Cincinnati Exposition Center
9:00 A.M.	Health Commissioners Institute	Cincinnati Exposition Center
9:00 A.M.	CURBSTONE CONSULTATIONS "Have You Cured Your Own Estate Problems?" Discussant Leader: Mr. Alan R. Vogeler, L.L.B., Cincinnati "The Welfare Problem: Is There A Solution?" Discussant Leader: Paul A. Jones, M.D., Zanesville "Immunization Idiocy" Discussant Leader: Marvin McClellan, M.D., Cincinnati	Cincinnati Exposition Center
9:00 A.M.	Continuation of Two-Day Clinicopathologic Symposium starting on Wednesday, May 10 Sponsored by the College of American Pathologists (CAP) and the Ohio Society of Pathologists in cooperation with the OSMA Section on Pathology	Cincinnati Exposition Center
9:00-11:30 A.M.	Section on Psychiatry and Ohio Psychiatric Association	Cincinnati Exposition Center
10:00 A.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
10:30 A.M.	Section on Obstetrics & Gynecology, Business Meeting followed by Scientific Program	Cincinnati Exposition Center
12:00 Noon	Luncheon Section on Psychiatry and Ohio Psychiatric Association	Stouffer's Cincinnati Inn
12:30 P.M.	OSMA Council Meeting Luncheon	Stouffer's Cincinnati Inn
1:00-2:30 P.M.	"Medical Student Field Assignment: A Link Between the College of Medicine and Community Health Service." Sponsored by OSU College of Medicine, Department of Preventive Medicine and OSMA Committee on Rural Health	Cincinnati Exposition Center
1:30 P.M.	Health Commissioners Institute	Cincinnati Exposition Center
1:30 P.M.	Section on Psychiatry and Ohio Psychiatric Association	Cincinnati Exposition Center

(Continued on Page 176)

INSIDE REPORT

Politics 1972

As a supporter of the Ohio Medical Political Action Committee and the American Medical Political Action Committee, you'll want to attend the . . .



ANNUAL OMPAC LUNCHEON

WEDNESDAY, MAY 10, 1972
(week of the OSMA Annual Meeting)

CINCINNATI EXPOSITION CENTER

Speaker...
Washington Columnist and Political Analyst
ROBERT D. NOVAK

Some facts about Mr. Novak...

If you will recall, Mr. Novak was the OMPAC speaker for the 1970 Annual Meeting and by popular demand is returning as our guest speaker at the 1972 OMPAC Luncheon. If you did not hear Mr. Novak in 1970 don't miss attending the 1972 OMPAC Luncheon. A treat will be in store.

In 1957, the Associated Press named him Capitol Hill correspondent in Washington, D.C. He joined the Wall Street Journal in 1958 as Senate correspondent and political reporter, and in 1961 became chief Congressional correspondent for the Journal.

In May 1963, Mr. Novak teamed with Mr. Rowland Evans, Jr. to write INSIDE REPORT, a political column, published five times a week. It is noted for its emphasis on reporting rather than punditry, and its rapidly moving dateline.

OMPAC LUNCHEON RESERVATION

WEDNESDAY, MAY 10, 1972 – 11:30 A.M.

Enclosed is $_____ to pay for:

_____ OMPAC Luncheon tickets @ $5.00 per person

Name:_____

Street Address:_____

City:_____

(Please pick up tickets at OSMA Registration Desk)

Mail to: Ohio State Medical Association, 17 South High Street, Suite 500
Columbus, Ohio 43215

ANNUAL MEETING SCHEDULE (Continued)

THURSDAY, MAY 11 (Continued)		
1:30 P.M.	Section of Physical Medicine & Rehabilitation and Ohio Society of Physical Medicine & Rehabilitation followed by Business Meeting	Cincinnati Exposition Center
2:00 P.M.	Section on General Practice	Cincinnati Exposition Center
2:30-3:00 P.M.	Break for Tour of Exhibits	Cincinnati Exposition Center
3:00-3:45 P.M.	"The Professional Liability Horizon" Speaker: Mr. Howard Snevel, A.M.A. Subject: The AMA's Approach to Professional Liability Insurance	Cincinnati Exposition Center
3:45-4:30 P.M.	Program to be developed on Informed Consent	
4:30 P.M.	Dismantle all Exhibits	Cincinnati Exposition Center

1972 Curbstone Consultation Seminars

Curbstone Consultations are being held two mornings during the 1972 OSMA Annual Meeting at the Cincinnati Exposition Center.

Register now for one of the Seminars, in the order of preference. Each Seminar will be limited to the first 30 persons registered in order to maintain a small, informal exchange of ideas and questions among those in attendance. If you are unable to attend, please notify the OSMA office so that your place may be assigned to someone else.

DISCUSSANT LEADERS AND SUBJECTS

Wednesday, May 10, 1972

Mr. William J. Lee, Columbus
Administrator, State Medical Board of Ohio
- "Know Your State Medical Board and Its Activities"

Anthony J. Ruppersberg, M.D., Columbus
Chairman, OSMA Committee on Maternal Health
- "OB Emergencies"

Donald J. Vincent, M.D., Columbus
Chairman, OSMA Committee on Medicine and Religion
- "What's Going On In Medicine and Religion?"

Thursday, May 11, 1972

Mr. Alan R. Vogeler, L.L.B., Cincinnati
Law Offices of Kyte, Conlan, Wulsin & Vogeler
- "Have You Cured Your Own Estate Problems?"
  (A Seminar on estate planning, including retirement and welfare plans, and Ohio and Federal income estate taxes)

Paul A. Jones, M.D., Zanesville
Chairman, OSMA Title XIX, Subcommittee of the Committee on Government Medical Care Programs
- "The Welfare Problem: Is There A Solution?"

Marvin McClellan, M.D., Cincinnati
Member, Academy of Medicine of Cincinnati Committee on School Health
- "Immunization Idiocy"

Wednesday, May 10, 1972
9:00 - 10:30 A.M.

(Indicate Order of Choice 1, 2, or 3)

☐ "Know Your State Medical Board and Its Activities"

☐ "OB Emergencies"

☐ "What's Going On In Medicine and Religion?"

Thursday, May 11, 1972
9:00 - 10:30 A.M.

(Indicate Order of Choice 1, 2, or 3)

☐ "Have You Cured Your Own Estate Problems?"

☐ "The Welfare Problem: Is There A Solution?"

☐ "Immunization Idiocy"

NAME (Please Print) _____

Address _____

_____

_____

(Mail this card to OSMA, 17 South High Street, Suite 500, Columbus, Ohio 43215)

Art Show Planned
FOR 1972 OSMA ANNUAL MEETING

Space will be provided at the 1972 Annual Meeting of the Ohio State Medical Association, May 9, 10 and 11, at Cincinnati Convention Center for a Physicians' Art Show. The Medi-Art Club of the Academy of Medicine of Cincinnati will merge their annual art exhibit with that of the Ohio State Medical Association at its annual meeting.

Members of OSMA and their wives interested in exhibiting pieces and requiring information regarding this can contact:

Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

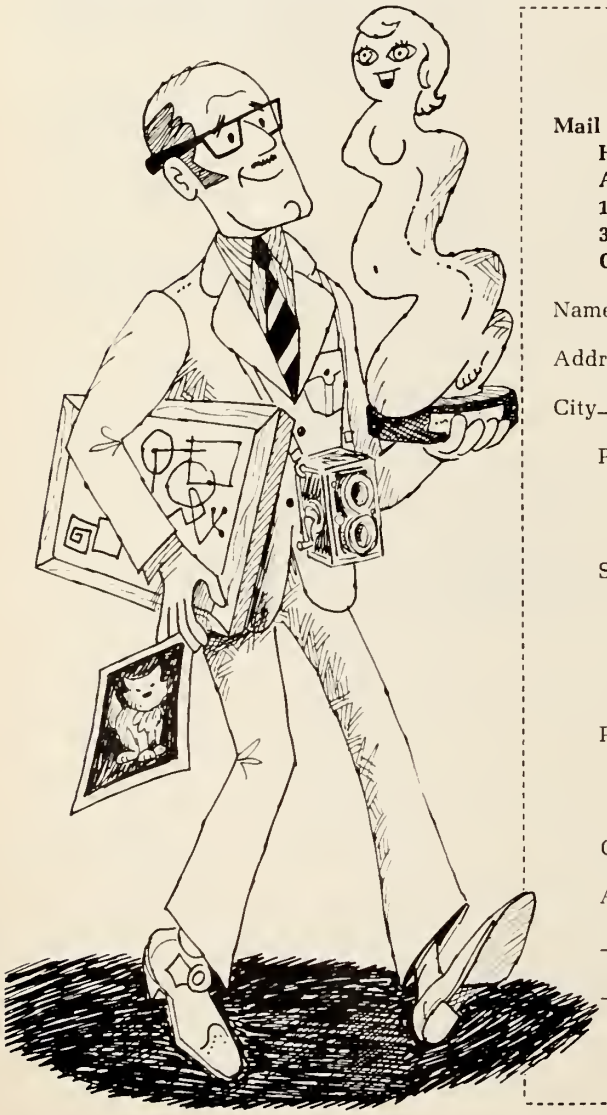
It will be the responsibility of each physician to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expenses involved in entering his or her exhibit.

Exhibitors will be limited to two art pieces per person. Please list in order of preference to be exhibited.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibit to make this an outstanding Art Show.



Application for Space in Art Show Exhibit

Mail to:
Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

Name_____

Address_____

City_____

Photography (must be mounted) _____

_____
(give dimensions)

Sculpture _____

_____
(give estimated size)

Check one: ☐ Pedestal type ☐ Wall type

Painting _____

_____
(give dimensions: depth, width and height)

Other information (which you believe will be helpful to the Art Committee) _____

_____

_____

(Deadline on Art Application to be announced)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold; acute and chronic sinusitis; vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake. Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F *Smith Kline & French Laboratories*

Trademark

ORNADE® SPANSULE®

brand of sustained release capsules

Each capsule contains 8 mg. of Teldrin®(brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

UNCOMMON RELIEF FOR COLD SYMPTOMS

OR-203

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.

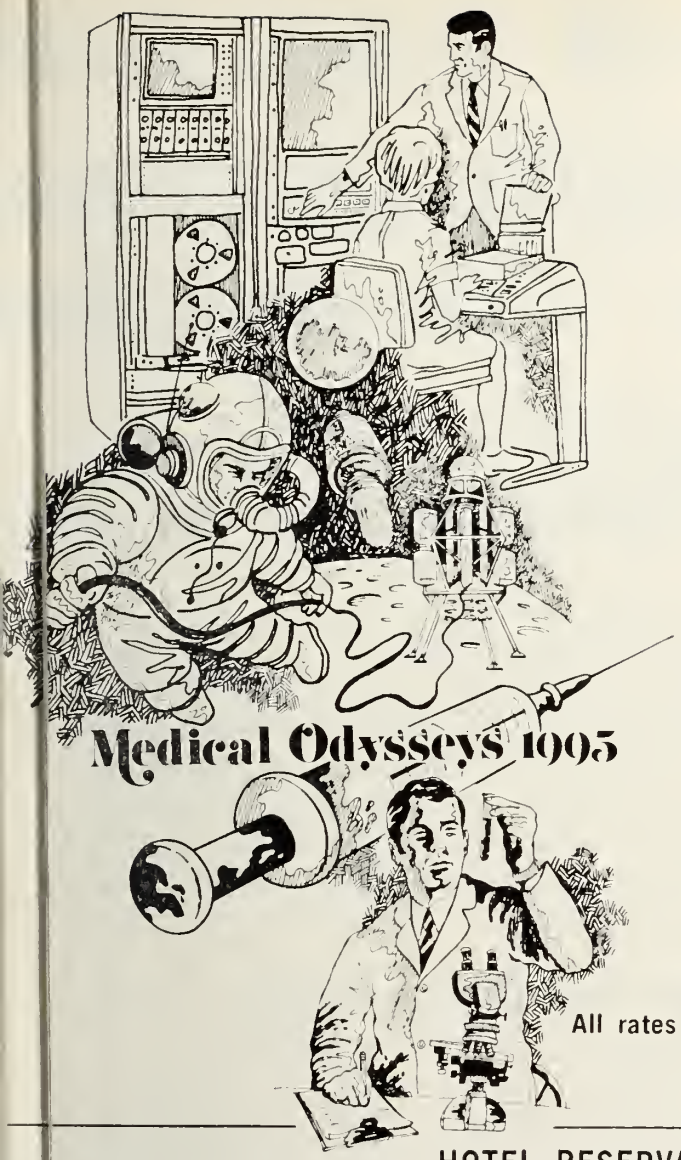


Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899



Make Your Hotel Reservations For The 1972 OSMA Annual Meeting

MAY 8-11
CINCINNATI, OHIO

STOUFFER'S CINCINNATI INN
150 West Fifth Street
Cincinnati, Ohio 45202
(OSMA Headquarters)

Singles	$17.50 - $23.50
Doubles	$22.50 - $27.50
Twins	$24.50 - $36.50

SHERATON-GIBSON HOTEL
421 Walnut St.
Cincinnati, Ohio 45201

Singles	$12.50 - $21.00
Doubles or Twins	$18.00 - $27.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK

Mail Today

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Cincinnati, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 8-11 (or for period indicated).

_____ Single Room _____ Twin Room

_____ Double Room Other Accommodations _____

Price Range _____ Guaranteed _____

Arrival: May _____ at _____ A.M. _____ P.M.

Departure: May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Name _____

Address _____

_____

A WHALE OF A MEETING

OSMA ANNUAL MEETING

MAY 8-11, 1972 CINCINNATI, OHIO

STOUFFER'S CINCINNATI INN – HEADQUARTERS HOTEL

CINCINNATI EXPOSITION CENTER – MEETING ROOMS AND EXHIBITS

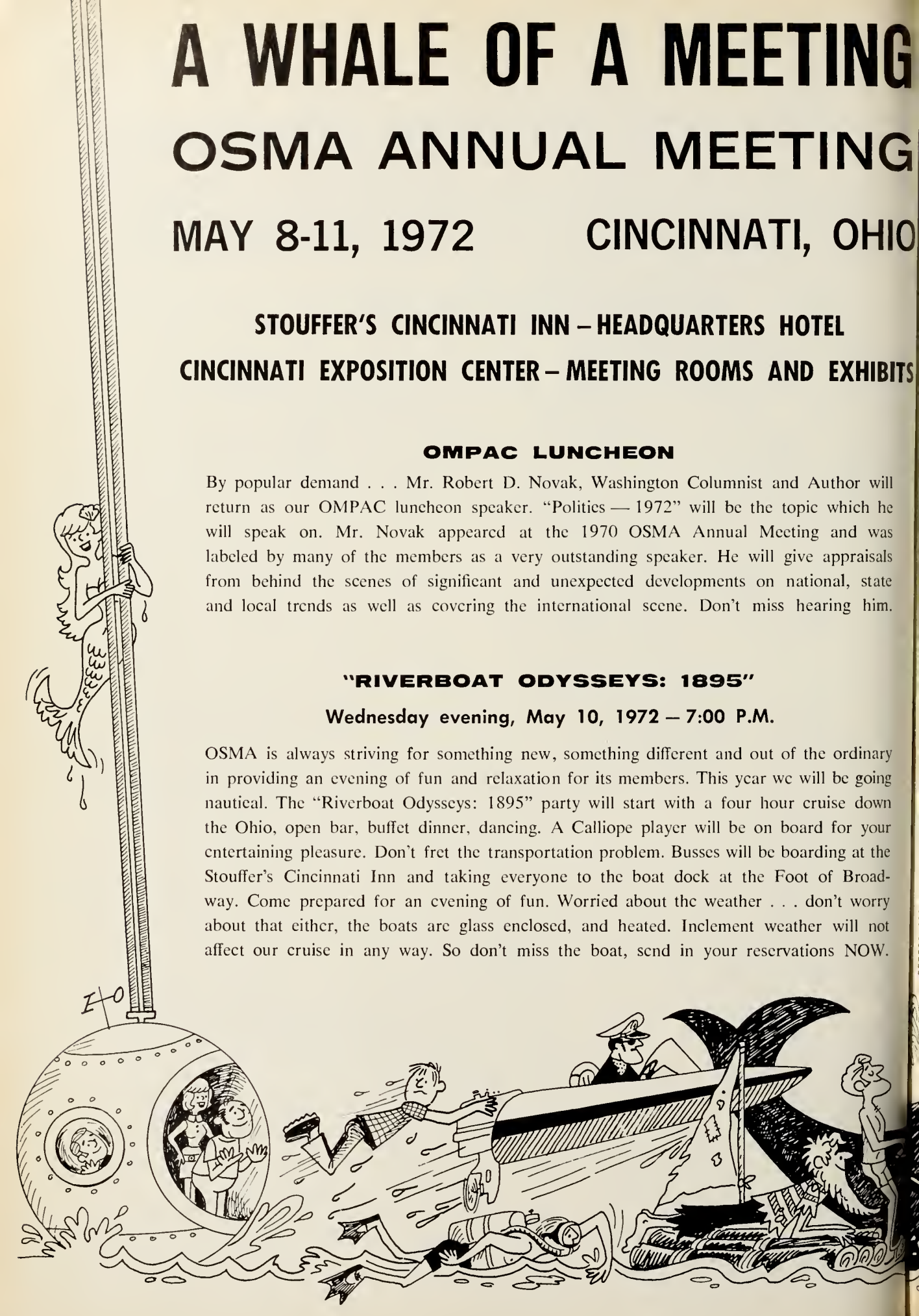
OMPAC LUNCHEON

By popular demand . . . Mr. Robert D. Novak, Washington Columnist and Author will return as our OMPAC luncheon speaker. "Polities — 1972" will be the topic which he will speak on. Mr. Novak appeared at the 1970 OSMA Annual Meeting and was labeled by many of the members as a very outstanding speaker. He will give appraisals from behind the scenes of significant and unexpected developments on national, state and local trends as well as covering the international scene. Don't miss hearing him.

"RIVERBOAT ODYSSEYS: 1895"

Wednesday evening, May 10, 1972 – 7:00 P.M.

OSMA is always striving for something new, something different and out of the ordinary in providing an evening of fun and relaxation for its members. This year we will be going nautical. The "Riverboat Odysseys: 1895" party will start with a four hour cruise down the Ohio, open bar, buffet dinner, dancing. A Calliope player will be on board for your entertaining pleasure. Don't fret the transportation problem. Busses will be boarding at the Stouffer's Cincinnati Inn and taking everyone to the boat dock at the Foot of Broadway. Come prepared for an evening of fun. Worried about the weather . . . don't worry about that either, the boats are glass enclosed, and heated. Inclement weather will not affect our cruise in any way. So don't miss the boat, send in your reservations NOW.



S PLANNED FOR YOU IN '72

PRE-REGISTRATION

All persons pre-registered may pick up their badge, program and tickets for OMPAC luncheon and "Riverboat Odysseys: 1895" party at the pre-registration desk in your name. Clip the coupon, fill out the information requested along with your **check in the proper amount** so that we may reserve tickets for you. This one step now will save you time later.

Annual Meeting Pre-Registration and Ticket Form

SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to: Ohio State Medical Association

Mail this form to: Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215

Wednesday, May 10, 11:30 A.M.

"OMPAC Luncheon"

Cincinnati Exposition Center

$5.00 per person

Number_____

Wednesday, May 10, 7:00 P.M.

"Riverboat Odysseys: 1895"

Johnston Party Boats
Foot of Broadway

$12.00 per person
(Special Price to Exhibitors of $9.00 per person)

Number_____

ame_____
(Please Print)

ddress_____
(Number and Street) (City) (State)

am:

☐ OSMA Member ☐ Medical Student

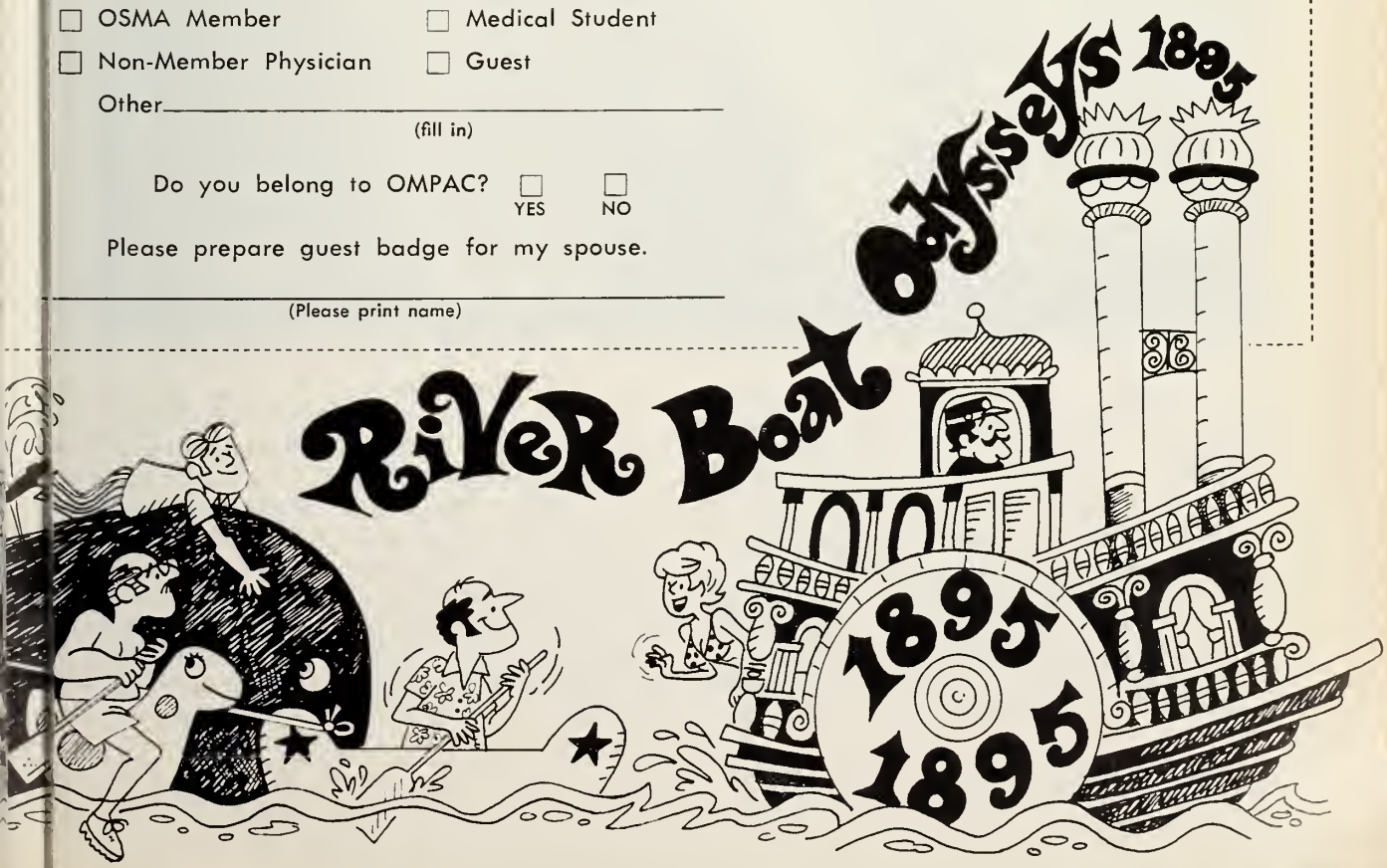
☐ Non-Member Physician ☐ Guest

Other_____
(fill in)

Do you belong to OMPAC? ☐ YES ☐ NO

Please prepare guest badge for my spouse.

_____
(Please print name)



Medical Historians to Meet in Columbus, April 8

The annual spring meeting of the Ohio Academy of Medical History will be held with the meeting of the Columbus area group of the Ohio Academy of Science History. The meeting is scheduled for Saturday, April 8 at the new Ohio Historical Society Museum building in Columbus near the 17th Avenue exit of I-71.

Genevieve Miller, Ph.D., Cleveland, is arranging a symposium on the history of medicine for the afternoon session. The morning session will be devoted to presentation of papers by members of both cooperating groups.

Contact may be made with the secretary-treasurer of the Ohio Academy of Medical History, Emanuel D. Rudolph, Ph.D., Department of Botany, Ohio State University, 1735 Neil Avenue, Columbus 43210.

Physicians Honored for Devoted Service



Dr. D. H. Downey, of Dover, left, holds the Certificate of Distinction just presented to him in behalf of the Ohio State Medical Association. The citation in part reads: "In recognition of his devotion to his patients, his contributions to the health and wealth of the public, and his allegiance to the principles of the medical profession . ." With him at the fall meeting in New Philadelphia are other members of the Tuscarawas County Medical Society, and third from left, Dr. Sanford Press, Steubenville, OSMA Seventh District Councilor, who made the presentation of the 50-Year Award.

The illustrations and write-ups on this and the facing page are two examples of events reported in local newspapers throughout Ohio. The New Philadelphia event was reported in the local *Times-Reporter.* The one in Napoleon was reported in the *Northwest Signal,* of Napoleon. Clippings coming into the headquarters office of the State Association indicate that many more local newspapers reported presentations of the 50-Year Certificate of Distinction. The Ohio State Medical Association awarded 65 such certificates in 1971 alone.



Members of the medical profession in Napoleon gathered to honor Dr. T. P. Delventhal for 50 years of devoted service in medicine. Dr. and Mrs. Delventhal are admiring the certificate and plaque just presented in behalf of the Ohio State Medical Association. Standing, from left, are Dr. George N. Bates, Toledo, OSMA Councilor for the Fourth District, who made the presentation; Dr. J. Julian Harrison, and Dr. Thomas F. Moriarty. Dr. Moriarty, who also is Mayor of Napoleon, holds a Proclamation proclaiming December 5 through 12 as "T. P. Delventhal, M.D. Week in Napoleon." On the table is a watch presented to Dr. Delventhal by the staff of Heller Memorial Hospital.

The Annual Family Medicine Review, sponsored by the University of Kentucky Medical Center has been scheduled on a new date — April 16-22. (The previously announced date was February 6-12.) For information on this program, contact Frank R. Lemon, M.D., Program Chairman, University of Kentucky Medical Center, Lexington, Ky. 40506. Fee is $175.

Cleveland Clinic Is Adding to Its Facilities

Now under construction is a $25 million addition to the Cleveland Clinic that will include a 330 bed hospital wing, a doctors' office building, and a research building.

Dr. Carl E. Wasmuth, chairman of the Board of Governors of the Cleveland Clinic Foundation, reported that the 330 beds will mean an increase of up to 10,000 more hospital patients a year, or approximately a 50 percent increase in patients served.

The cardiovascular disease diagnostic suites are designed, Dr. Wasmuth said, to be three times more efficient than any similar units in use today. It is anticipated that the unit will accommodate more than 70 cardiovascular patients a day, two and a half times the present capacity. The new cardiovascular surgery suite will mean that surgery can be performed on an additional 1250 patients a year.

The doctors' office building will allow space and facilities for a 30 percent increase in outpatient service. One of the world's largest x-ray departments will occupy nearly an acre of floor space. The Clinic's research scientists will occupy the new research building. It is estimated that construction will take 30 months.

What To Write For

Guide for Hospital Committees on Transfusions — Published by the American Medical Association, the pamphlet contains the position statement of the AMA on blood banks and other guides regarding blood procurement, storage and uses. The pamphlet also contains reference to other literature on the subject. Write Committee on Transfusion and Transplantation, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

Information Relating to Alcoholism — For information on programs of the National Institute on Alcohol Abuse and Alcoholism, write to the Department of Health, Education and Welfare Regional Office serving your area, or to National Institute on Alcohol Abuse and Alcoholism, 5600 Fishers Lane, Rockville, Md. 20852.

New State Income Tax

NEW ON THE OHIO SCENE is a personal and corporate income tax, accompanied by several other changes in the state tax structure. The new tax law was passed by the Ohio General Assembly late in 1971 and became effective January 1, 1972.

In general, the new law contains a corporate income tax of 4 or 8 percent with a $25,000 breaking point, or a 5-mill tax on net worth, whichever is greater; a graduated personal income tax of 0.5 to 3.5 percent; a severance tax on coal and certain other natural products; a 1-mill increase in the tax on domestic insurance companies, dealers in intangibles, and financial institutions; a reduction in the personal property tax on inventories, furniture, and fixtures; a 3-cent increase in the cigarette tax; and an increase in the mixed beverage tax from 40 to 80 cents a gallon.

Also provided is a 10 percent reduction in real estate property taxes beginning with next June's tax bill and a homestead exemption for persons 65 or older beginning with next December's tax bill.

State Income Tax

Under the new tax law, employers are required to withhold from employees' wages amounts prescribed. A booklet, Employers Ohio Income Tax Withholding Instructions and Tables, and tax forms have been mailed to employers who are on record as receiving federal tax forms. Copies of the booklet and tax forms may be obtained from the State of Ohio Department of Taxation.

Ohio withholding procedures have been patterned after federal procedures as far as record keeping, reporting, and payment is concerned.

All employers maintaining offices or transacting business in Ohio who are required to withhold federal tax are required to register by completing and filing Form IT-1, Application for Registration as a Withholding Agent, with the Ohio Department of Taxation. The Ohio employer identification number is the same as the federal identification number. Instructions on exclusions from withholdings, forms to be filed, etc., are explained in the booklet.

The book of instructions lists tables for calculating amounts of withholdings.

The physician as a self-employed person is scheduled to receive proper forms for filing an estimated tax. Any person who has filed as a self-employed individual will be on federal computer records and thus will also receive state tax forms and instructions. Persons filing for the first time may obtain forms from the Ohio Department of Taxation district office or from a local bank.

The schedule for the new tax is as follows (based on adjusted gross income as it appears on federal IRS returns):

First $5,000	0.5 percent
$ 5001-10,000	1 percent
$10,001-15,000	2 percent
$15,000-20,000	2.5 percent
$20,001-40,000	3 percent
$40,001 plus	3.5 percent

$500 per person exemption may be claimed up to a maximum of $3,000.

Physicians who practice both in Ohio and a neighboring state may wish to inquire as to reciprocity or pending reciprocity on income tax between these states. All surrounding states now have an income tax, and reciprocity is being sought for those persons who find themselves subject to taxes in two states.

There is no allowance as far as state and municipal taxes are concerned. In other words, physicians who are subject to municipal income taxes may pay them in addition to the state income tax.

Obituaries

Bernard Botsch, M.D., Toledo; University of Maryland School of Medicine, 1929; aged 66; died December 19; member of OSMA and AMA; Fellow, American College of Obstetricians and Gynecologists, American College of Surgeons, and International College of Surgeons; diplomate, American Board of Obstetrics and Gynecology; practitioner in Toledo for 39 years; served as lieutenant commander in the Navy during World War II.

Warren Conrad Fargo, M.D., Cleveland; State University of New York at Buffalo, School of Medicine, 1913; aged 81; died December 21; member of OSMA, AMA, and American Academy of Pediatrics; diplomate, American Board of Pediatrics; practitioner of long standing in the Cleveland area; former editor of the *Bulletin* of the Academy of Medicine of Cleveland; veteran of both World Wars I and II.

Starr Ford, Sr., M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; aged 66; died November 27; member of OSMA and AMA; practitioner of long standing in Cincinnati; recently medical consultant to the Kroger Company; retired as colonel in the Ohio State Guard. Dr. Starr Ford, Jr., is his son.

Robert S. Gillette, M.D., Toledo; Marquette University School of Medicine, 1928; aged 72; died November 29; member of OSMA and AMA; general practitioner in Toledo beginning in 1928; commander in the Navy Medical Corps during World War II. Survivors in the professional field include his sons, Dr. Robert D. and Dr. William B.; also a brother, Dr. Norris Gillette.

Morris Michael Groban, M.D., Dayton; University of Michigan Medical School, 1934; aged 62; died December 5; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in the Dayton area for 35 years.

John Bailey Hall, M.D., Geneva; Western Reserve University School of Medicine, 1939; aged 60; died November 25; member of OSMA, AMA, and American Society of Anesthesiologists; practitioner in the Ashtabula County community since 1946, specializing in anesthesiology; served in the Army Medical Corps during World War II.

Joseph Hornstein, M.D., Cleveland; medical degree from the Royal University of Budapest, 1917; aged 86; died November 26; former member of OSMA; practitioner in the Cleveland area for 50 years.

Ole Cleveland Jackson, M.D., Woodsfield; Medical College of Georgia, 1927; aged 87; died December 8; former member of OSMA; practitioner of long standing in the Woodsfield area and former Monroe County health commissioner.

Frank Henness Jones, M.D., Columbus; Ohio State University College of Medicine, 1925; aged 69; died December 1; member of OSMA and AMA; general practitioner for 40 years in Columbus; served in the Army Medical Corps during World War II.

Nevin John Murray Klotz, M.D., Wadsworth; Ohio State University College of Medicine, 1936; aged 67; died November 20; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in Wadsworth since 1938; medical director of the Wadsworth Health Center; among activities, was president of the Ohio Chapter of the Flying Physicians Association.

Donald Ray Lyon, M.D., Chagrin Falls; Western Reserve University School of Medicine, 1948; aged 47; died December 20 in a traffic accident; member of OSMA, AMA, American Society of Internal Medicine; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner in the Chagrin Falls area for a number of years; military service during and following World War II.

Gordon Frederick Meuser, M.D., Columbus; Ohio State University College of Medicine, 1922; aged 72; died December 6; general practitioner for many years in Columbus.

Benjamin Nozik, M.D., Shaker Heights and Cleveland; Western Reserve University School of Medicine, 1928; aged 68; died December 11; member of OSMA, AMA, American Academy of Allergy, and American Physicians Fellowship; Fellow, American College of Allergists; practi-

tioner for some 43 years in the Cleveland area, specializing in allergy; veteran of World War II.

Chester Reeves Nuckolls, M.D., Cleveland; University of Virginia Medical School, 1928; aged 68; died December 20; member of OSMA, AMA, American Urological Association; Fellow, American College of Surgeons, and International College of Surgeons; diplomate, American Board of Urology; practitioner in the Cleveland area since 1930; served in the Navy Medical Corps during World War II.

Walter Edwin Obetz, M.D., Columbus; Starling Medical College, Columbus, 1909; aged 86; died December 29; member of OSMA and AMA; general and industrial practitioner of many years standing in Columbus before his retirement.

Paul Purvins, M.D., Newton Falls; State University of Latvia School of Medicine, 1939; aged 57; died December 18; member of OSMA, AMA, and American Academy of Family Physicians; native of Latvia; began intern and residency training in Cleveland in 1949 before opening his practice in the Newton Falls area.

Urban Daniel Seidel, M.D., La Verne, Calif.; University of Michigan Medical School, 1905; aged 93; died December 2; member of OSMA and AMA; diplomate, American Board of Otolaryngology; practitioner in Akron, specializing in the EENT field until his retirement in 1940; resident of California since 1941.

James Frederick Seliskar, M.D., Cleveland; Western Reserve University School of Medicine, 1934; aged 63; died November 17; member of OSMA and AMA; practicing physician for many years in Cleveland, specializing in cardiology; also medical officer at the Armed Forces Receiving Station, and physician for city employees.

Wilson Poole Shortridge, M.D., Perrysburg; Temple University School of Medicine, 1938; aged 58; died December 12; member of OSMA, AMA, and the American Psychiatric Association; practitioner in the Toledo area for a number of years and specialist in psychiatry since 1958; served in the U. S. Air Force during World War II.

James F. Treon, M.D., Aurora, Indiana; Medical College of Ohio, Cincinnati, 1903; aged 91; died November 20; practiced for many years in Indiana in the Cincinnati vicinity.

Louis Joseph Zupp, M.D., Tulare, Calif.; Western Reserve University School of Medicine, 1937; aged 63; died December 4; former member of OSMA; diplomate of the American Board of Anesthesiology; formerly practiced in Ravenna; moved to California in 1955.

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

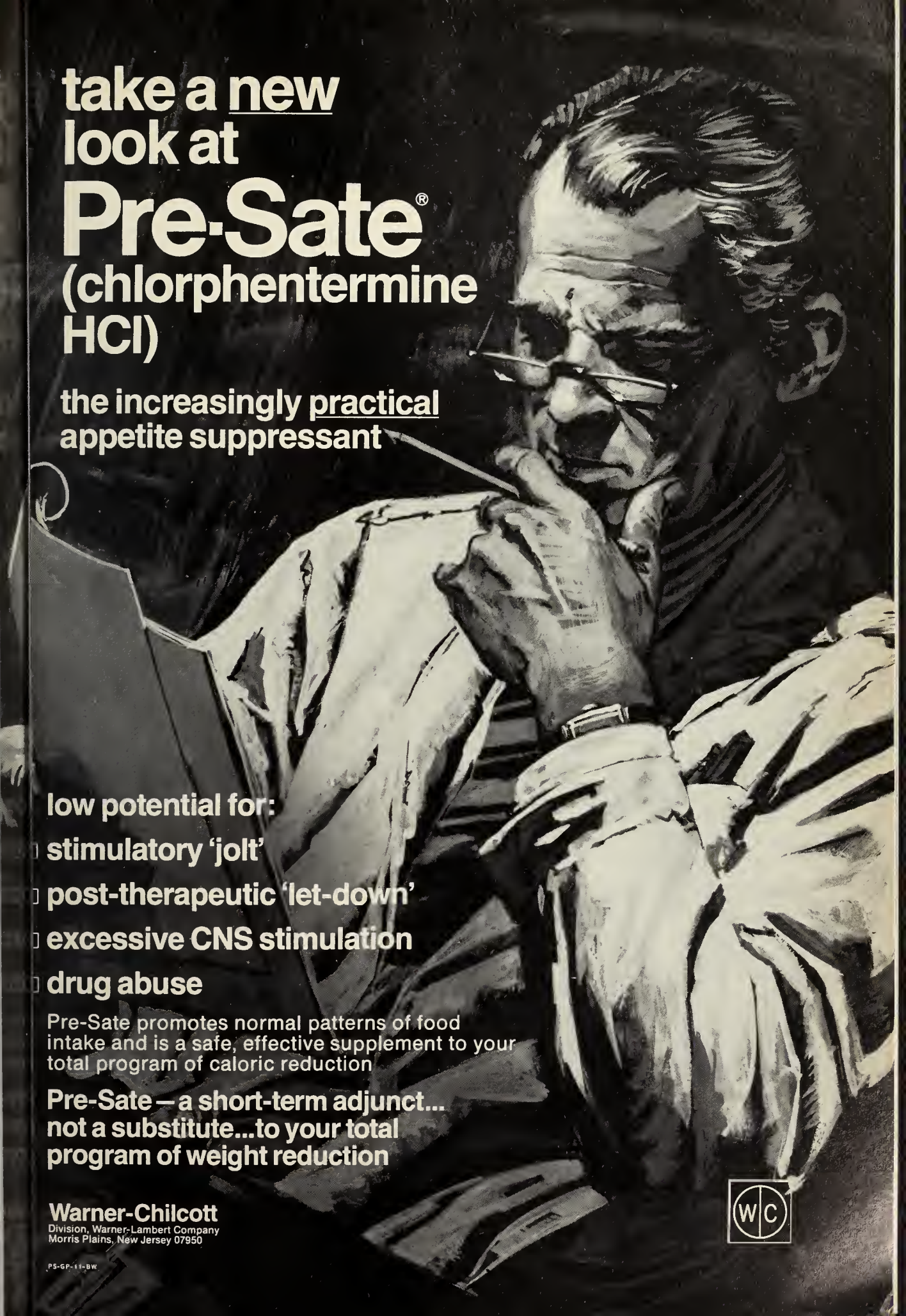
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.


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When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains of neumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

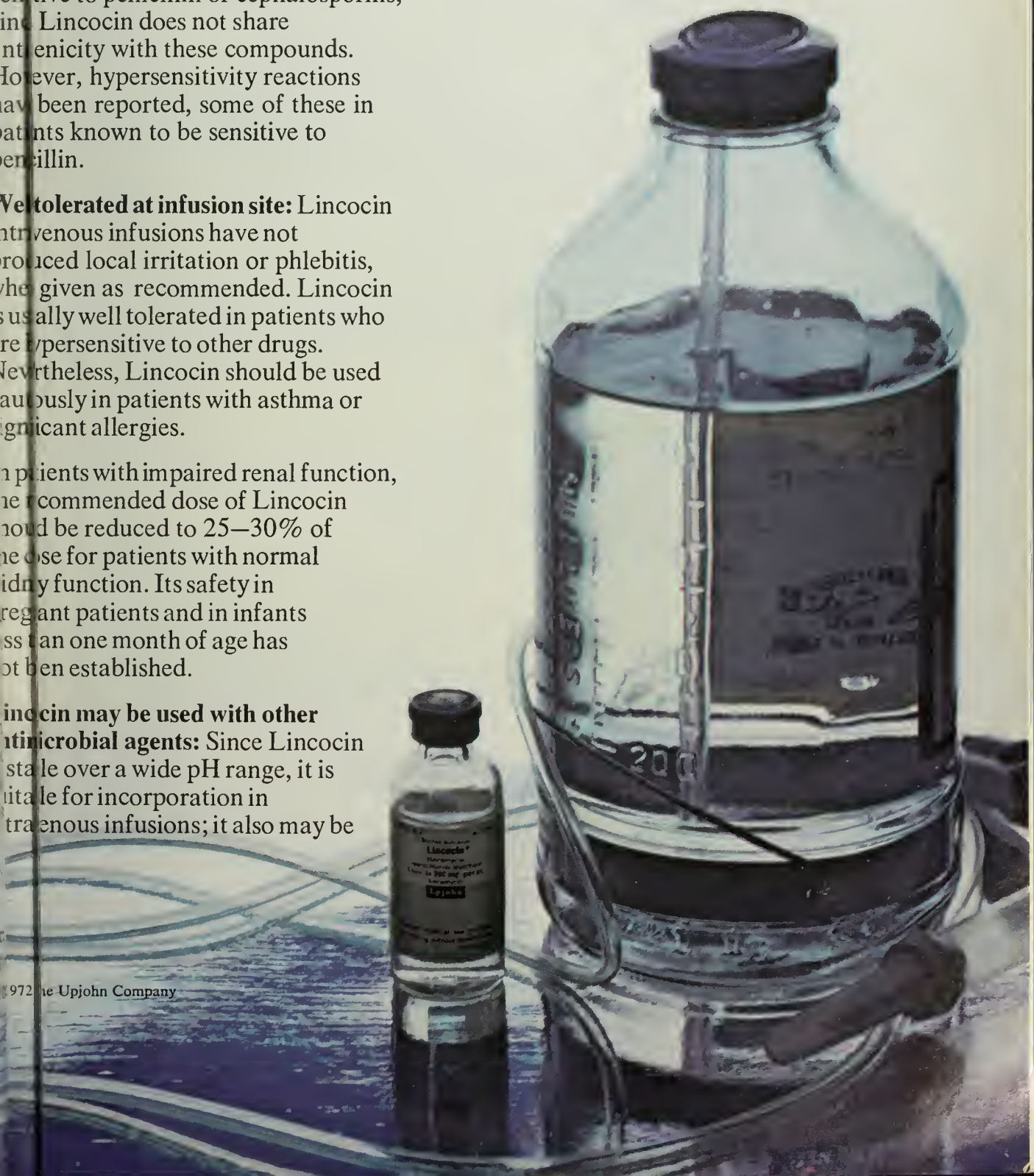
Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatm... *Skin and mucous membranes*—Skin ra... urticaria, vaginitis, and rare instances of ... foliative and vesiculobullous dermatitis ... been reported. *Liver*—Although no direct ... lationship to liver dysfunction is establi... jaundice and abnormal liver function ... (particularly serum transaminase) have ... observed in a few instances. *Cardiovasc...* —Instances of hypotension following p... teral administration have been repor... particularly after too rapid IV adminis... tion. Rare instances of cardiopulmonary ... rest have been reported after too rapid ... administration. If 4.0 grams or more ad... istered IV, dilute in 500 ml of fluid ... administer no faster than 100 ml per h... *Special senses*—Tinnitus and vertigo ... been reported occasionally. *Local react...* —Excellent local tolerance demonstrat... intramuscularly administered Linco... (lincomycin hydrochloride). Reports of ... following injection have been infrequ... Intravenous administration of Lincocin ... 250 to 500 ml of 5% glucose in dist... water or normal saline has produced ... local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500* ... Capsules—bottles of 24 and 100. *St...* *Solution, 300 mg per ml*—2 and 10 ml ... and 2 ml syringe. *Syrup, 250 mg per 5* ... —60 ml and pint bottles.

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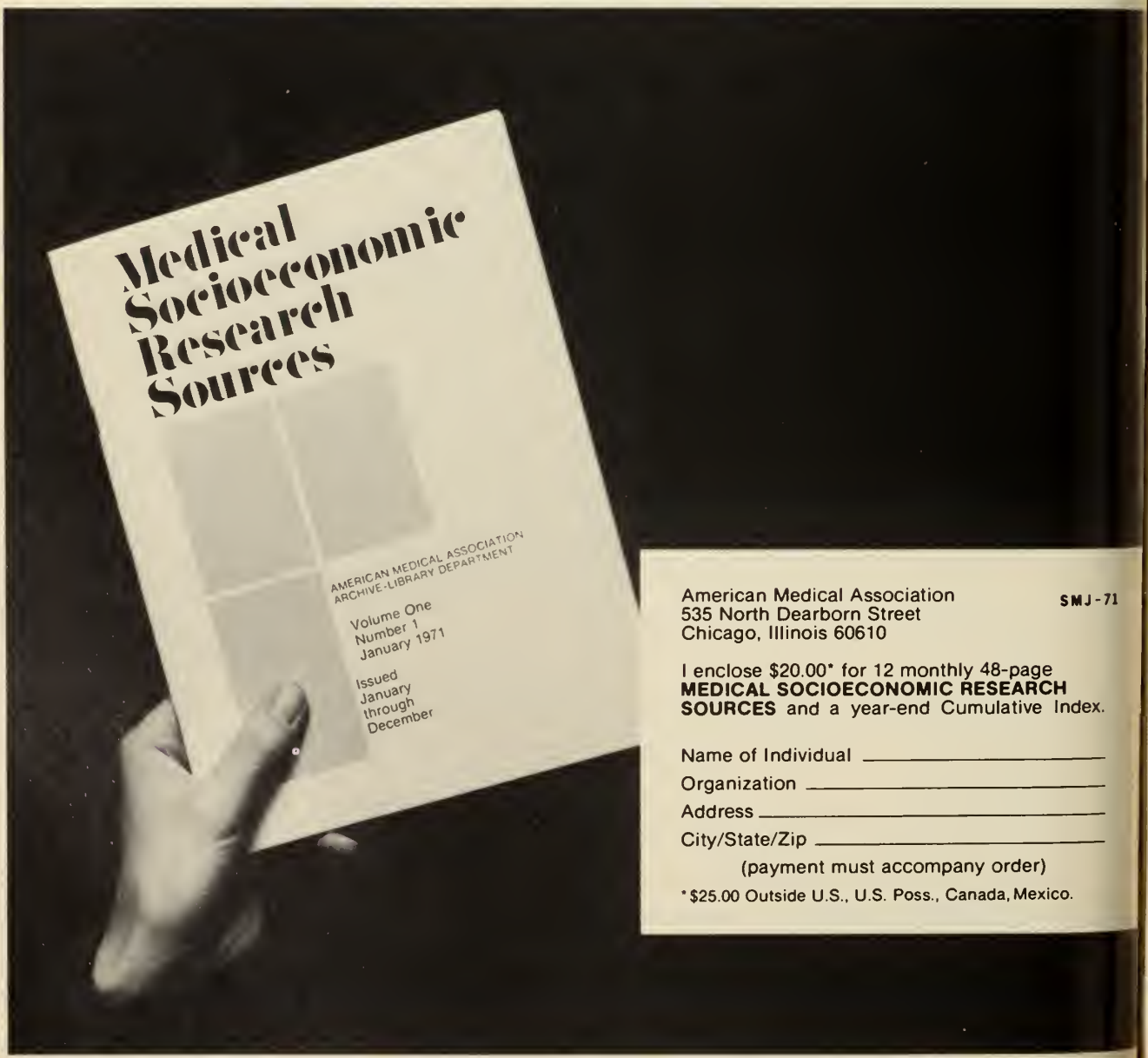
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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

IT WAS A MOVING EXPERIENCE — Scioto County auxiliary's recent visit-meeting at the Happy Hearts School in Portsmouth. I use it as my lead story this month of a bleak February because there is warmth and there is sunshine filtering through from that visit. It was such a wonderful opportunity to sit in on the classes and activities of those children and young adults with multiple handicaps and witness the superb job being done for them.

The students — and indeed they are all of that — were lively and affectionate and greeted the local doctors' wives with enthusiasm. There were the sounds of happy laughter; there was friendly curiosity. And between the staff of nine teachers and three assistants, there was unmistakable rapport with their charges. If there was a momentary twinge for these handicapped children, it became quickly lost in the atmosphere of hope and endeavor that permeates the school.

The children are brought to school each day from all over Scioto County; that special bus covers a distance of 580 miles daily. Emphasis is placed on motor coordination, communication skills and academic work to the ability of the individual. There are even toilet training, baths and clean clothes for those in need of them. For the young adults, there are ten special programs (the oldest such student is 35 years old; she looks more like a teen-ager). On display were beautiful handicraft items made by the older students.

A nearby public school prepares the luncheons each day that are served at the Happy Hearts School. For those who cannot afford to pay, the food is served without charge. The Mental Retardation Board which supervises the activities and programs of the school is appointed by the Juvenile Court judge. One such Board member must be the parent of an enrolled child. The pay scale of the teachers is considerably below that of other teachers in the public schools — $4,000 annually — but these women are so dedicated that it just doesn't seem to matter. I found, after speaking to some of them, that they looked upon their jobs as a God-given privilege to be able to help the less fortunate.

The Happy Hearts School is one of Scioto auxiliary's pet projects. From time to time, the group plays fairy godmother and provides some needed articles, or money for a particular something. In my mind's eye, I see again the clean, well-equipped school, the little girl who determinedly shook the hand of each visitor and said "welcome," the smiling little boy who became intrigued with my watch. And above all, I see the positive, warm and beautiful way these handicapped children and young adults are being lovingly adjusted to a more normal way of life. A great big salute to all such projects everywhere . . .

WA-SAMA

An orchid to *The Spectrum* — the informative, interesting and sparkling publication of WA-SAMA (the Woman's Auxiliary to the Student American Medical Association). These wives of students, interns and residents — *our* future mem-

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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bers — are living proof of what a group of aware young women can accomplish. By helping each other, they of course help themselves. But even more important, they have started on the path to service for the medical profession. The newest project is "Happy Birthday, Baby" in cooperation with the National Foundation March of Dimes and works to help make possible better infant births. Some 60,000 children and adults die each year from birth defects, a half million are destroyed before birth, and seven percent of all live births survive with defects.

The November-December issue of *The Spectrum* detailed some seven "specifics" for the young student doctors' wives to get the ball rolling on "Happy Birthday, Baby." From the map in this latest issue earmarked with WA-SAMA chapters, I counted some 51 such groups. (The dots on the map were so tiny that my eyes could easily have overlooked a few!)

Not every county auxiliary can lend a hand in help and friendship to WA-SAMA, since obviously chapters are to be found only where there are medical students, interns and residents associated with the university centers. But there's one way of helping so that these young doctors' wives can expand the group's many national programs and institute new ones: By becoming sustaining members of the organization — for a mere $5 annually. The established doctor's wife who becomes a sustaining member of WA-SAMA is saying, in effect: "You are our hope for the future . . . Welcome . . ."

Would you like more detailed information on WA-SAMA? Have you made out a check for $5 and wonder to whom it should be sent? Write to our Ohio Auxiliary's liaison — Mrs. Floyd Beman, 310 E. Torrence Road, Columbus 43214.

On Mental Health

State auxiliary chairmen are busy people, and no one more so than Mrs. Armin Melior, mental health chairman. Here are some of her pertinent comments and observations: "Since mental illness is America's most pressing and complex health problem, the Auxiliary's goals are directed toward: 1) promotion of mental health education to acquire a basic knowledge and understanding of mental hygiene, human behavior and emotional 'first aid' and 2) service to the mentally ill and retarded.

"From our yearly county auxiliary reports comes this picture of Ohio activities: volunteer work at county mental health clinics; service on Mental Health Association Boards; help with Child Guidance Clinics and retarded children; volunteer work and financial assistance at Drug Abuse Centers; gifts and parties for mental patients; money and parties for retarded children; money to support campaigns to pass mental health levies; help with rehabilitation programs.

"Do you know that behind the bell (the symbol of the National Mental Health Association) is a real bell? Its weight is 300 pounds. In 1953, in Baltimore, it was cast of melted down chains and shackles which had restrained mentally ill patients in the past. It proclaims a new understanding and approach to mental illness. In this new direction, much has to be done in the field of education. People must be made to realize that the mentally ill are patients who are troubled and need help. Mental health is everybody's business. There is no limit to becoming involved . . . The National Auxiliary office offers such special 'package programs' as Mental Health in Children, Drug Abuse and Alcoholism. There is also available a wealth of booklets, pamphlets and movies from the American Medical Association and the National Mental Health Association. County auxiliaries are doing a superb job in this direction. But many should be doing more!"

"Our" Women

We're mighty proud of two of our outstanding doctors' wives: Mrs. Christopher Colombi, of Cleveland, a past state president who also served on the national level, and Mrs. Robert Krone, of Cincinnati, my immediate predecessor as Publicity Chairman and current Convention Chairman.

Vi Colombi is serving her third consecutive term as president of Cleveland's Women's City Club and recently was awarded the "Halo of the Week" by newspaper columnist Milt Widder for her part in bringing to reality the Club's magnificent new quarters. Last year, Mayor Carl Stokes declared a "Vi Colombi Day" for her tremendous and successful work with the handicapped. At the reception at the Women's City Club to honor Cleveland's new Mayor Ralph J. Perk and Mrs. Perk, the Colombis were on the receiving line to greet the guests as they arrived.

Fran Krone is a columnist in her own right with the *Cincinnati Post* and *Times-Star,* one of three dietitians who share in the writing of the weekly "Ask The Dietitian." Says Fran: "There are three of us who have been writing the column for over a year. One writes a column, sends carbons to the other two gals. Then, by phone, we 'criticize' each other. The author incorporates the suggestions of the other two and sends the final product to the paper. It appears each week in the food section. We receive questions by mail, dream up a few ourselves or pick up verbal comments for inspiration. It's fun and educational!"

Fran who is a member of Cincinnati's Dietetic Association sent me a clipping of the column on last December 8 bearing her by-line. It was

a lively, well-written and definitely informative "production." It centered around the factors of nutrients in bread — of whole wheat versus white bread. And there was an intriguing recipe on a "Three Flour Bread." I'm not much of a cook, but I'm going to try out that recipe one of these days, it sounds so doggone good! And healthful . . .

Trumbull-Way

"Word to the Wives" is Trumbull County's newsletter — pithy, informative, interesting. It goes out monthly to its membership. The newsletter is such an effective way of "keeping in touch." More and more auxiliaries are joining the newsletter bandwagon. I'd love to see the time when every county auxiliary issues one. I've said it before and I say it again: No auxiliary is too small to have one! Or, for that matter, too big . . .

On November 11, the Trumbull auxiliary gathered at the Avalon Inn for a luncheon and to hear the dynamic Dr. Jack Schreiber speak. The doctor (also well known for his tricks of magic) discussed the many medical problems that exist in the United States today and the pros and cons of national health insurance. He ended his talk with this comment: "Freedom is a fragile thing; the Statue of Liberty is a woman."

Mrs. K. P. Swisterski, auxiliary president, welcomed the members and guests. Mrs. J. J. Stanislaw, program chairman, expressed thanks to her committee for their endeavors on this luncheon meeting. Mrs. J. S. Schlect, community service chairman, discussed Trumbull County's successful Mobile Meals project which celebrated its first anniversary on November 23rd. Mrs. S. Yumang, AMA-ERF chairman, urged members to contribute generously to the Foundation in its efforts to help the medical schools and medical students in need of financial help. New members introduced by Mrs. D. H. Chickering, membership chairman, were Mrs. Vincent Demacanapolis and Mrs. Alston Quillin.

"Christmas Coffee"

On December 1, Trumbull's doctors' wives met at St. Paul's Lutheran Church for their annual "Christmas Coffee." Sixty members attended. Among the special guests were: Mrs. Manuel Abendan, wife of a resident at Trumbull Memorial; Mrs. Luis Cali, wife of an intern at Trumbull Memorial; and the auxiliary's honorary members. The Senior Company of the Warren Civic Ballet Company presented a beautiful program, under the direction of the prominent choreographer, Alex Martin of the Cleveland Ballet Guild. And Mrs. B. E. Goodman, oldest member of Trumbull's auxiliary, shared some inspirational and provocative thoughts with the group. The social hour followed the meeting and program. Mrs. Goodman presided over the festive holiday-decorated tea table.

One More Day

February brings St. Valentine's Day — and is appropriately dubbed "Heart Month" by the American Heart Association. This 1972 it also brings Leap Year — and that 29th day. It would be such a fine thing if everybody everywhere gave that extra day to helping someone somewhere somehow. Perhaps we could dub it Thoughtfulness Day. Come to think of it, there are not nearly enough such days, are there?

Medical Society Must Provide Forum for Political Discussion

"We need a forum to express our views so that spokesmen for medicine can represent a consensus."

There's an awful lot of truth to the above observation by a local medical society officer in connection with the political activity of the medical profession.

The local medical society, wherever located, should provide that "forum." It can if it will. It provides an opportunity for its members to discuss and learn about what's new on the medical front. Why not do the same with respect to political and public affairs matters — actually bread-and-butter topics in this day and age?

Some say the Ohio Medical Political Action Committee should serve this function. NOT AT ALL. OMPAC does not have the facilities or type of organization necessary for this kind of job. The local medical society does.

At the forums which the local medical society can, and should provide, members can debate the public affairs (political) issues and talk about the qualifications of candidates for public office. **There are no legal or ethical barriers to educational activities of this kind.**

By doing as suggested, members will be providing the medical leaders of the society, as well as themselves, with a "consensus." This will provide the chosen leaders with guides to be followed in their contacts with the public. It will give them information which can be passed on to OMPAC to help it make its decisions as to which candidates to assist at a forthcoming election.

Actually, OMPAC gets information and advice on which to base its decisions from medical leaders — state and local. Thus local medical leaders can be of inestimable help to OMPAC by keeping themselves in tune with the views of the majority of the physicians of their society. Obviously, the society must provide its leaders with a way through which they can get the "consensus." Unless this is done, little can be accomplished.

Those who think the medical society can forget political discussion and action, within the bounds of the law and good taste, now that a "PAC" has been formed, are badly mistaken.

Each has its place and purpose. The medical society must be the fountainhead of discussion, information and advice on public affairs (including political matters). The function of the Ohio Medical Political Action Committee is to raise money which can be used to assist in the election of candidates who can measure up to the standards set by the medical society through discussion and debate. The function of one is educational; the other to engage in the rough and tumble of political campaigning.

Right now is the time for physicians everywhere to make their 1972 OMPAC contribution of $25.00 at the same time they pay their Medical Society dues.

In those parts of Ohio where these two units have been able to coordinate their activities as herein suggested, the political influence of the medical profession has taken on real meaning. Otherwise, it has been a flop and "the doctor vote" continues to be a mystery. In these perilous times, the medical profession can't afford to have its views and decisions on public questions (including political matters) cloaked in mystery.

—Ohio Medical Political Action Committee

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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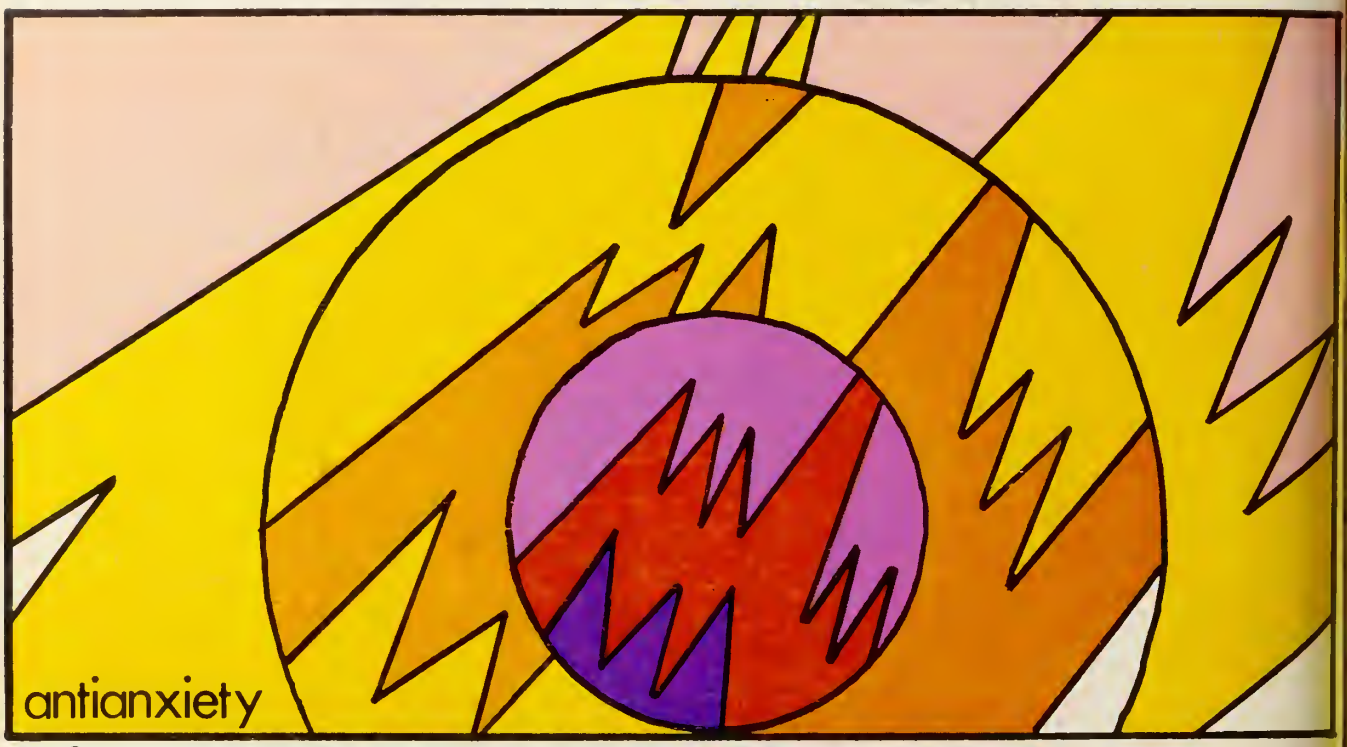
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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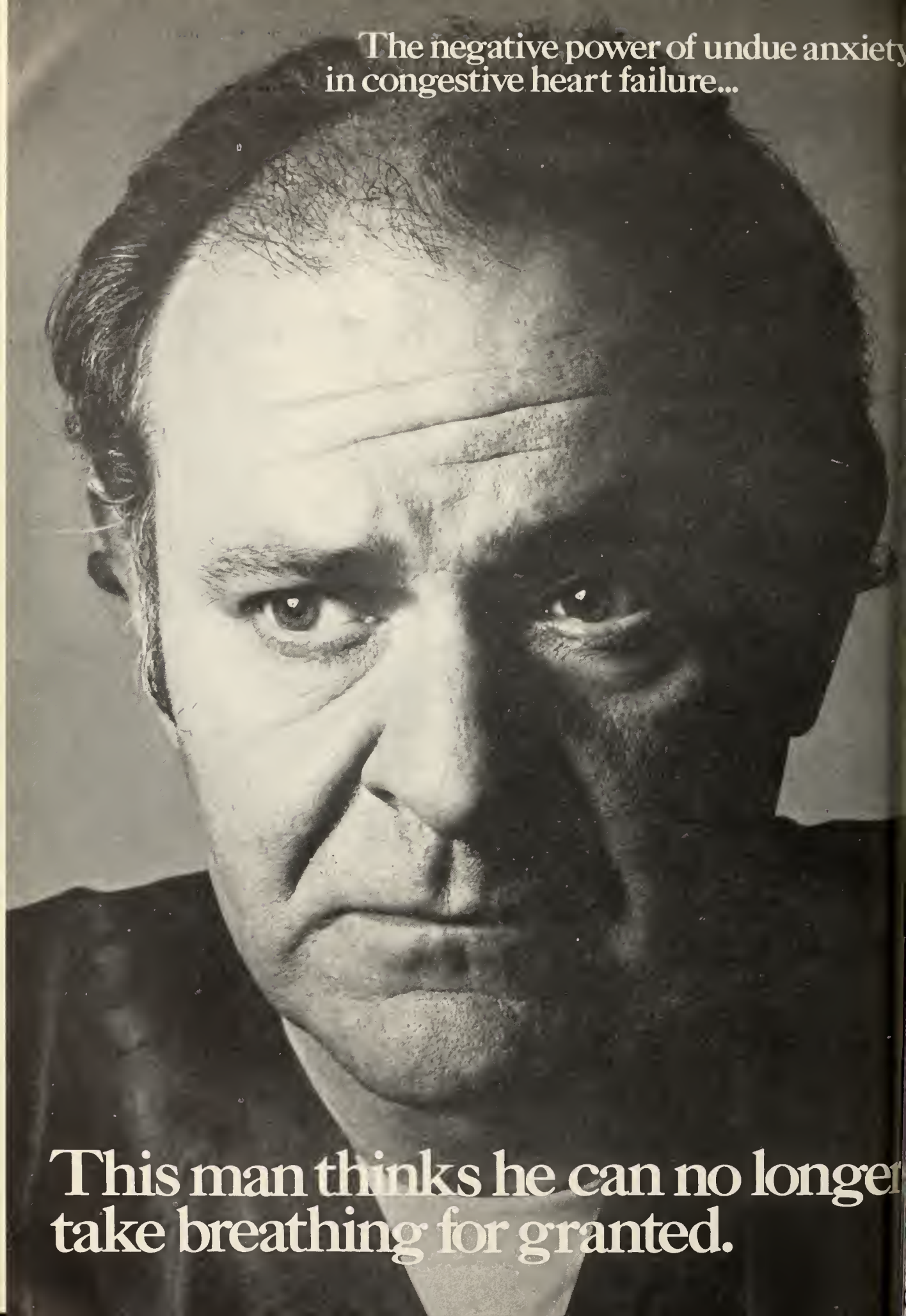
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EXCHANGE OFFICE
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The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

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Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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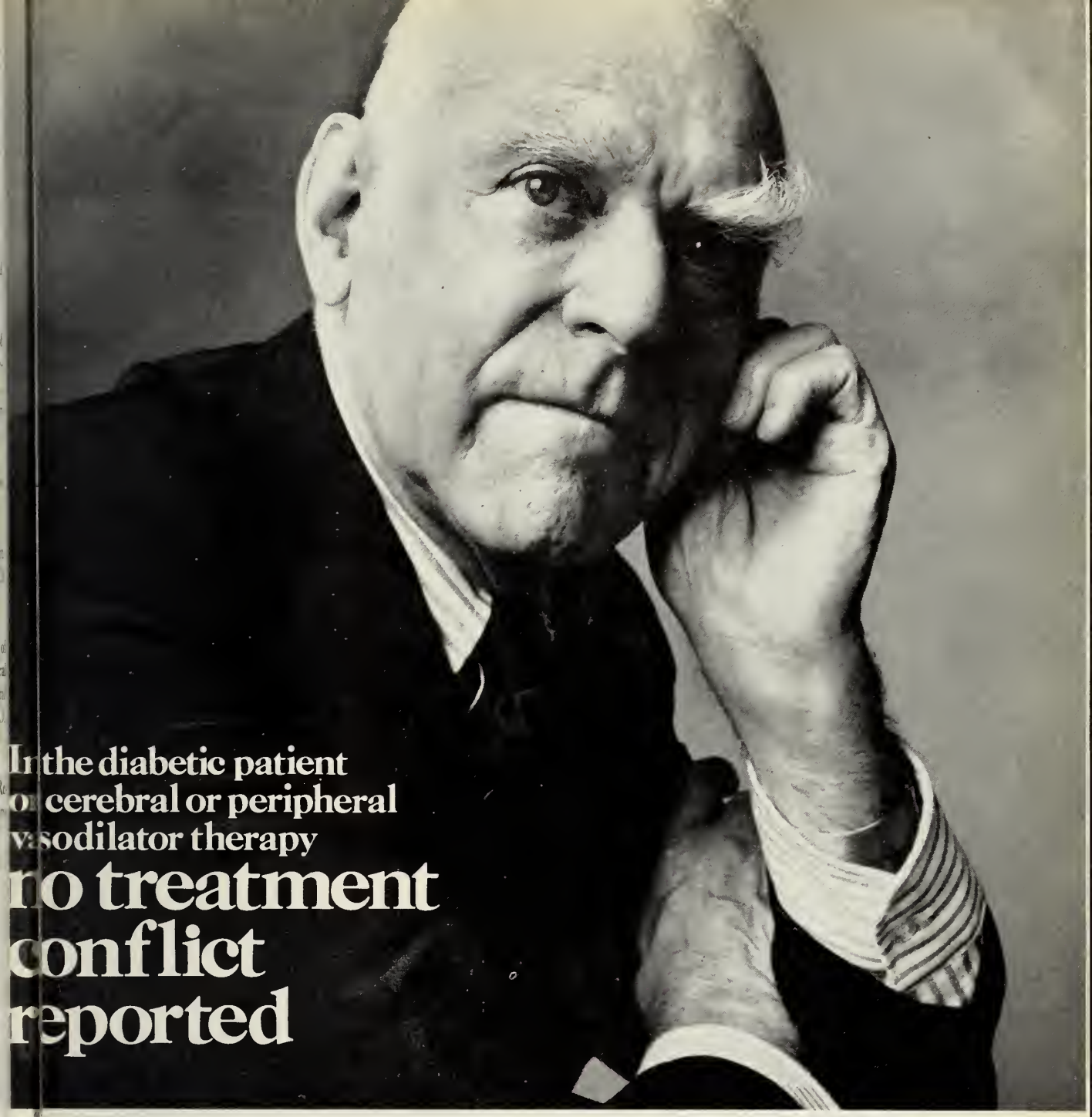
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(Continued on Page 306)



In the diabetic patient
or cerebral or peripheral
vasodilator therapy

no treatment conflict reported

VASODĪLAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic. **Composition:** VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (3) Norton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

Mead Johnson LABORATORIES

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MDs in the News

Dr. Robert G. Page, dean of the Medical College of Ohio at Toledo, took office in January as chairman of the Midwest-Great Plains Group of the Association of American Medical Colleges. The group covers a 12-state area and includes 28 medical colleges and 130 hospitals in Ohio, Nebraska, Minnesota, North and South Dakota, Iowa, Illinois, Indiana, Wisconsin, Michigan, Missouri, and Kansas.

Dr. Lawrence J. McCormack, of Cleveland, has been elected to serve as speaker of the House of Delegates of the American College of Pathologists.

Dr. Arthur G. James, professor of surgery at Ohio State University and director of the Columbus Cancer Center, will be installed as president of the American Cancer Society at its 1972 annual meeting. He was named vice-president and president-elect at the fall meeting of the organization.

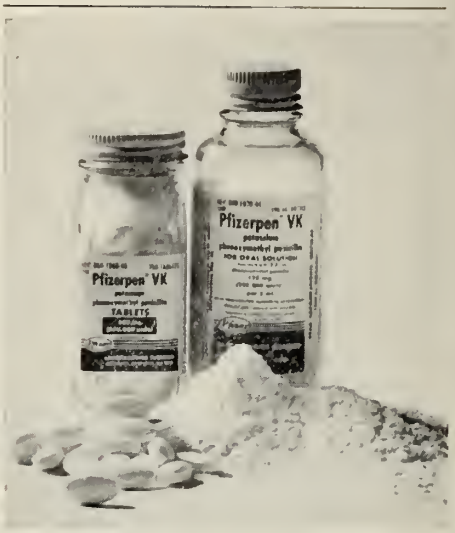
Dr. Walter A. Hoyt, Jr., director of the Orthopaedic Departments of Akron City Hospital and Akron Children's Hospital, was named first vice-president of the American Academy of Orthopaedic Surgeons at the organization's 39th annual meeting in Washington. Dr. Hoyt will be the Academy's 1973-1974 president.

The Wayne State University Press of Detroit has published a volume of essays by Cincinnati neurologist Dr. Charles D. Aring under the title *The Understanding Physician.*

Dr. Henry A. Crawford, Cleveland, has been named to a new ten-member AMA Advisory Committee on Cancer. This is the first committee on a specific disease established by the AMA. Dr. Crawford is a Past President of the Ohio State Medical Association and an Ohio Delegate to the AMA.

A series of seminars on the Vietnam veteran, held in five cities last year during April and May, under the sponsorship of the Veterans Administration are reported fully in a 65-page booklet available free of charge from: Veterans Administration Information Service, 810 Vermont Avenue, N.W., Washington, D.C. 20420.

PFIZERPEN DOSAGE FORMS



Orange-flavored
Pfizerpen VK for Oral Solution
(potassium phenoxymethyl penicillin)
125 mg. (200,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.
250 mg. (400,000 units)/5 cc.:
bottles of 100 cc. and 150 cc.

Pfizerpen VK Tablets
(potassium phenoxymethyl penicillin)
250 mg. (400,000 units): bottles of 100.
500 mg. (800,000 units): bottles of 100.



Butterscotch-caramel-flavored
Pfizerpen G Powder for Syrup
(potassium penicillin G)
400,000 units/5 cc.:
bottles of 100 cc. and 200 cc.

Pfizerpen G Tablets
(potassium penicillin G)
200,000 units: bottles of 100 and 500.
250,000 units: bottles of 100.
400,000 units: bottles of 100 and 1000,
and unit-dose pack of 100 (10 x 10's).
800,000 units: bottles of 100.

Pfizer LABORATORIES DIVISION
PFIZER INC NEW YORK N Y 10017

PFIZERPEN®
COMES THROUGH AGAIN.



Now there are *two* ways to cut the cost of brand-name penicillin therapy.

Pfizerpen VK now joins Pfizerpen G (potassium penicillin G) for *true* economy in brand-name penicillin therapy.

When you write penicillin VK, it's for acid stability, solubility and rapid absorption. But when you write **Pfizerpen VK**, you add economy. Pfizerpen VK, more economical than the two leading brand-name penicillin VK products. G or VK. Just make sure it's Pfizerpen.

Tablets and Powder for Syrup

PFIZERPEN® VK
(POTASSIUM PHENOXYMETHYL PENICILLIN)
G OR VK. JUST MAKE SURE IT'S PFIZERPEN.



the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, anger, and frustration. It's very likely that these psychic factors actually accentuated his perception of pain. Surely the last thing he needs is an analgesic containing caffeine. A much more logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

A. H. Robins Company, Richmond, Va. A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. *Contraindications:* Hypersensitivity to any of the components. *Precautions:* As with all phenacetin-containing products, excessive or prolonged use should be avoided. *Side effects:* Side effects are uncommon, although nausea, constipation and drowsiness may occur. *Dosage:* Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

(III) Phenaphen with Codeine is now classified in Schedule III, Controlled Substances Act of 1970. Available on prescription and may be refilled 5 times within 6 months, unless restricted by state law.



Snifter working again

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

A·H·ROBINS

A. H. Robins Company
Richmond, Va. 23220

Dimetapp® Extentabs®

Dimetane® (brompheniramine maleate), 12 mg., phenylephrine HCl, 15 mg., phenylpropanolamine HCl, 15 mg

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

HAMILTON
Pramod R. Rege
Cincinnati

SCIOTO
Arnaldo Leon
Wheelersburg

* * *

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January.

ASHTABULA
Eduardo Y. Coligado
Geneva

DELAWARE
Samuel J. Ambler
Delaware

JEFFERSON
(Steubenville)
Fernando L. Ayala
Bernard Greenhouse

LAKE
Keung Bai Kim
Wickcliffe
Mohammed H. Rezaee
Willoughby

MADISON
Theodore J. Froncek
West Jefferson

MARION (Marion)
H. Richard Hobe
Roger A. Robinson
Dennis W. Rowland
Felix S. Ruivivar

MUSKINGUM
Richard H. Gier
Zanesville

STARK (Canton, except as noted)
Fadhil K. Abbousy
Angelo J. Demis
Robert N. DiSimone
John A. Fike
William T. Martin
Massillon
Robert B. Packer
W. Sam Park
Jerry Rothenberg
Alliance
Tippur N. R. Seshagiri
Frank P. Urso
Massillon
May J. Urso

A two-year grant amounting to $46,053 has been announced for the University of Cincinnati College of Medicine by the Hartford Foundation, of New York City. Under the grant, Dr. Paul T. Russell and Dr. A. R. Shade, assistant professor of obstetrics and gynecology, will conduct research on "The Role of Lipids in Toxemia of Pregnancy."

When you prescribed Orinase®

(tolbutamide, Upjohn)

14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-

Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase®

0.5 g tablets

(tolbutamide, Upjohn)

cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001

Upjohn

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Mahoning County Society Enters Hundredth Year

This year marks the one-hundredth anniversary of the founding of the Mahoning County Medical Society, an article in the January issue of the Society's Bulletin reports. The founding date was November 13, 1872.

"The Society is the oldest organization of professional men in the city or county," reports Dr. John C. Melnick, author of the article. "We are most fortunate to have in our possession the original minutes as handwritten in ink, and very legible, by our first secretary, Dr. W. J. Whelan. This is indeed an extremely valuable piece of Youngstown's history, and it has been this author's privilege to read page by page the history of our Society."

Three meetings were held in 1872. The minutes of the first meeting as originally written read as follows:

"Youngstown, Ohio, November 13, 1872

"The physicians of this city, having held a meeting at the office of Dr. Cunningham & Brooke, the following business was transacted:

"Dr. Woodbridge in the Chair. Dr. Whelan, secretary. After some conversation, a motion prevailed that we organize ourselves into an association to be known as the Mahoning County Medical Society.

"On motion, a committee was appointed to draw up a constitution and by-laws: Dr. Brooke, Dr. McCurdy, Dr. Woodbridge, Jr., Dr. Whelan—Committee.

"The meeting on motion adjourned to meet two weeks from date at the office of Drs. Woodbridge & McCurdy."

The author continues by explaining that Drs. Cunningham & Brooke's office was located at 2 West Federal Street. Without doubt, the Dr. Woodbridge referred to was Timothy; not Dr. James E. Woodbridge. Dr. Whelan was W. J. Whelan, the father of Dr. R. E. Whelan.

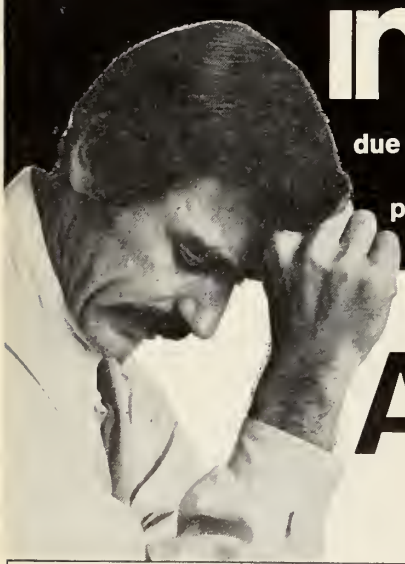
The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References. 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12 69, 1966 2. **Dubin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5 67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25 6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 863, 1958. 6. **Dsol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

On the next two pages:
An important announcement
for you and your patients.

New from Colgate:

Superior Gram negativ



Effective against Gram positive bacteria and Gram negative bacteria.

As mild as any other toilet soap. With unsurpassed substantivity for long-lasting antibacterial action.

Active ingredients: 3, 4′, 5-tribromosalicylanilide and 4, 2′,4′-trichloro-2-hydroxy diphenyl ether. Together these agents produce a synergistic effect that provides broad spectrum protection against skin bacteria. (P-300 does not contain hexachlorophene.)



The new all-purpose soap for homes, offices, hospitals, schools, restaurants, food processing plants, laboratories, etc.

P-300: Superior protectio

Athletic Training Manual Available

Of special significance is a new publication issued recently under the title *Fundamentals of Athletic Training.* It is a joint project of the National Athletic Trainers Association, the Athletic Institute, and the American Medical Association's Committee on Medical Aspects of Sports.

The significance of this manual is indicated in the first paragraph of the preface: "In the past few years it has become increasingly evident that health care of athletes is a cooperative affair. Physicians, athletic trainers, coaches, game officials, parents, and others related to organized sports activities, have responsibilities for the athletes' good health, prevention and treatment of injuries, and rehabilitation after illness and injury. However, those who have the greatest responsibility are physicians and athletic trainers, because of their intimate relationship to medical aspects of sports."

The preface is written by Thomas E. Shaffer, M.D., of Columbus, chairman of the AMA Committee on the Medical Aspects of Sports. Numerous well-known trainers and physicians involved in sports medicine made contributions to the text or acted as reviewers.

The 128-page paperback booklet discusses relationship of the various persons involved in athletic training, facilities and equipment, health supervision, methods of conditioning, adaptation to environment, protective taping, first aid, care of the injured, etc.

Order from the AMA, 535 N. Dearborn Street, Chicago, Illinois 60610; $2 in the U. S., possessions, Canada and Mexico; 11 or more copies, $1.50 each. $1.50 to medical students, interns and residents.

AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS BUCCAL Tabs

Methyltestosterone N.F.-5 mg.

Android® 10

Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy 17-Methylandrost-4 en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

BROWN

THE BROWN PHARMACEUTICAL CO., INC.
2500 West 6th Street, Los Angeles, California 90057

The new Rocom™ Medical Management System...

helps solve these five vexing office problems

1. taking health histories
2. maintaining meaningful patient records
3. handling incoming telephone calls
4. keeping appointments on schedule
5. providing useful supplemental patient instructions

Each component in the new ROCOM Medical Management System* deals with a specific office problem to help you provide better patient care and improve the use of your office time.

In designing these products, hundreds of doctors, nurses and receptionists were consulted about their particular office problems. More than two years of development under actual office conditions proved that the ROCOM systems actually do help solve difficulties without upsetting existing office routines.

In private or group practice, most physicians will find one or more of these products useful. The components can be employed alone, in various combinations, or preferably as the complete ROCOM Medical Management System, depending on your own office situation. To obtain additional information, please send this coupon to ROCOM -- the health information and education division of Hoffmann - La Roche Inc.

*Created and developed by Patient Care Systems, Inc.

1. ROCOM Health History Syste

provides maximum screening information about the patient with a minimum expenditure of your time. Prior to your examination, the patient answers 129 carefully chosen questions arranged by body system. Only positive answers transfer through to the summary sheet. You get an immediate picture of the patient's current complaints with the knowledge that important screening questions are covered.
SOMETHING NEW...ROCOM HEALTH HISTORY SYSTEM (Spanish) -- Questions are in Spanish, answers in English. The form does the "translating."

2. ROCOM Medical Record System

a simple but comprehensive method for keeping a complete record on every one of your patients. Permits you to review a patient's medical history in seconds and retrieve information quickly. Can be used with the "problem-oriented" method of keeping patient records. Color coding virtually eliminates the likelihood of misplaced files. A disease cross-index card keeps track of patients by disease entity. Family Jacket Holder keeps all medical records of an individual family in one location. Well-kept records can be one of the greatest deterrents to malpractice suits. The ROCOM Medical Record System helps protect your good name.

3. ROCOM Telephone System

a complete system; one that can be understood quickly by your newest office aide; one that permits your staff to answer specific patient questions with confidence; one that will make your practice more productive by assuring that you are interrupted only when you think it necessary. Self-adhesive backing assures that all incoming calls can become part of the patient's permanent record.

4. ROCOM Appointment System

worked out by you in your own practice with the help and guidance of ROCOM. Time segments are individualized to your own requirements. Can be coordinated with your colleague's or nurse's schedule. Helps keep a steady flow of traffic through the waiting room. An unlimited variety of schedules available.

5. ROCOM Patient Health Guide

a series of 25 education aids that provide basic knowledge to supplement your counselling and instructions. Follows a question and answer format. Tested for accuracy and effectiveness in private medical practices. This literature is "patient-oriented" not "product-oriented." A convenient holder for storage of the Guides is also available.



2.





4.





ROCOM™

ROCHE

Division of Hoffmann-La Roche Inc.
Box 169
Fairview, New Jersey 07022

Gentlemen:
I am interested in obtaining additional information about:

- ☐ Health History System
- ☐ Patient Health Guides
- ☐ Telephone System
- ☐ Appointment System
- ☐ Medical Record System

Name _____ Specialty _____

Street _____

City _____ State _____

Please do not forget Zip Code _____

MMS-38

Scandinavian Adventure

Two-Week Tour Beginning July 11, Sponsored by the Ohio State Medical Association

A 14-DAY Scandinavian Adventure holiday for members of the Ohio State Medical Association was recently announced by P. John Robechek, M.D., President. Departure date for the trip to Stockholm, Helsinki and Copenhagen is July 11, 1972 from Cleveland or Columbus.

The special Scandinavian Adventure price of $798 plus $40 tax and service includes chartered round trip jet transportation, deluxe hotels, two meals daily (American breakfast in your hotel and gourmet dinners at a choice of the finest restaurants in each city), tips, transfers and many other extras to make your trip more enjoyable. The baggage allowance has been increased to a generous 70 pounds, more than adequate allowance for shopping and your golf clubs.

There is absolutely no regimentation on the Scandinavian Adventure. You are free to go where you want, do what you want—when you feel like doing it! You may join in group activities or explore on your own.

A special Scandinavian Adventure escort will travel with you throughout the trip. In Stockholm, Helsinki and Copenhagen you will have five personable hosts to assist in arranging sightseeing, shopping, golfing, nightclubbing and other activities.

Fly direct to Stockholm from Cleveland or Columbus via chartered World Airways 707 private jet with first class service aboard, including stretch-out, extra comfort seating, the finest food and complimentary cocktails and champagne.

For four days in Stockholm, you will stay at the new luxurious Sheraton-Stockholm Hotel located in the very center of town. You will be welcomed with outstanding accommodations, assuring you of a delightful and memorable stay.

Stockholm is a city set on islands and rocky bluffs overlooking a lovely harbor. This still growing metropolis of strikingly beautiful landscape and handsome modern architecture is a fascinating mixture of old and new where you'll spend your days in discovery. You'll thrill to the magnificent Millesgarden sculptures, the stateliness of Drottningholm Palace and its charming Court Theater. Visit Old Town whose youthful heart is still full of laughter. Stroll cobblestone streets, wander into quaint antique shops. Peek into handkerchief sized courtyards and explore 13th century alleys.

You'll find more delights in the Swedish shops—glistening Orrefors glass and crystal, pottery, pewter and silverware. There's also famous Swedish cutlery and tableware, textiles, luxurious furs and glittering jewels.

The incredible Swedes with their exuberant zest for life must have invented happiness—and good food is part of that happiness. Dine . . . in splendor at a choice of elegant restaurants featuring lavish smorgasbord tables of unending taste-tempting delights. Try a "snaps" or aquavit with your meal. Or relish the delicate flavor of cloudberries in cakes and ices.

From Stockholm you can take a short flight to the fascinating **Isle of Gotland** to see the ancient walled city of Visby. Or visit the Uppsala-Sigtura Lake Country of exquisite churches and old picturesque towns. You'll also want to marvel at the Wasa—the carving encrusted 17th century warship recently excavated and being restored in Stockholm harbor.

You'll also have the opportunity to take an **optional side trip to Oslo** . . . Norway's capital, spectacularly situated on a glistening blue fjord. There's so much to see—the Kon Tiki raft, Viking Ship Museum, Olympic Ski Jump and the charming Norse Outdoor Folk Museum.

Then on to Helsinki for four days in the sparkling capital city of Finland called the white city of the North. You can't help loving Helsinki and its friendly atmosphere . . . a land, where the Midnight Sun shines through most of the long summer nights.

You'll stay at the newly completed Inter-Continental Hotel. Here you can relax in your room or in the luxury of a Finnish Suana bath. You'll have a choice of Helsinki's finest restaurants. The food is marvelous.

Cruise one of Finland's bright waterways past gaily painted wooden houses into the vast

(Continued on Page 226)

Come To The Land Of The Vikings



OHIO STATE MEDICAL ASSOCIATION

Scandinavian Adventure

Stockholm • Helsinki • Copenhagen

Departing: Cleveland and Columbus

July 11, 1972

Spend two fun-filled weeks of carefree discovery in spectacular Sweden, Finland and Denmark. Fly direct to Scandinavia via World Airways 707 private jet.

Our Scandinavian holiday features the finest deluxe hotels in each city . . delicious international cuisine . . . the ultimate in VIP service . . . plus all the freedom of individual travel at charter savings.

You'll travel in relaxed luxury . . . there's never any regimentation just do as you please. Optional sightseeing tours are available each day You'll have plenty of time for shopping in world famous department stores or quaint little shops You'll find it ALL in Scandinavia

Scandinavian Adventure price is only $798 per person. Space is strictly limited. Complete the reservation form and return it today.

Send to: **Ohio State Medical Association**
17 S. High Street — Suite 500
Columbus, Ohio 43215

Enclosed is my check for $ _____
($100 per person as deposit.)

☐ Please send full color brochure.

Name _____

Home Address _____

City State Zip Code Phone

★

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CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmermann

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter



LIPO-NICIN® NICOTINIC ACID THERAPY

RELEASES NICOTINIC ACID 2 WAYS *QUICKLY* OR *GRADUALLY*

For Treatment of:

COLD FEET
LEG CRAMPS • TINNITUS
DISCOMFORT ON STANDING
WHEN ASSOCIATED WITH IMPAIRED PERIPHERAL CIRCULATION

ALSO PROVIDES CONCOMITANT ADMINISTRATION OF THE LISTED VITAMINS.

AVAILABLE IN THREE STRENGTHS

QUICK RELEASE

NOT TIMED
LIPO-NICIN®/100mg.
Each blue tablet contains:

Nicotinic Acid	100 mg
Niacinamide	75 mg
Ascorbic Acid	150 mg
Thiamine HCl (B-1)	25 mg
Riboflavin (B-2)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 5 tablets daily
AVAILABLE: Bottles of 100, 500, 1000.

NOT TIMED
LIPO-NICIN®/250mg.
Each yellow tablet contains:

Nicotinic Acid	250 mg
Niacinamide	75 mg
Ascorbic Acid	150 mg
Thiamine HCl (B-1)	25 mg
Riboflavin (B-2)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 3 tablets daily
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

TIMED RELEASE 6 to 8 HOURS
LIPO-NICIN®/300mg.
Each capsule contains:

Nicotinic Acid	300 mg
Vitamin C (Ascorbic Acid)	150 mg
Vita. B1 (Thiamine HCl)	25 mg
Vitamin B2 (Riboflavin)	2 mg
Pyridoxine HCl (B-6)	10 mg

DOSE: 1 to 2 capsules daily
AVAILABLE: Bottle of 100, 1000.
In a special base so prepared that the active ingredients are released over a period of 6 to 8 hours.

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

Write for Literature and Samples

BROWN The BROWN PHARMACEUTICAL COMPANY, INC.,
2500 West 6th Street, Los Angeles, California 90057

REFER TO PDR

IN ASTHMA
IN EMPHYSEMA



optional therapy

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula

First choice

MUDRANE-2

When ephedrine is too exciting or is contraindicated

MUDRANE GG

During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2

A counterpart for Mudrane-2

MUDRANE GG ELIXIR

For pediatric use or where liquids are preferred

Clinical specimens available to physicians.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

wilderness of spruce and birch forest. There is fascinating scenery as far as the eye can see.

You won't want to miss the **two-day excursion to Leningrad.** Peter the Great's St. Petersburg was founded in 1703 as Russia's "Western window on the world." It's a city of stately baroque buildings, towering steeples and graceful bridges where Count Stroganov, created Beef Stroganov and Chicken Kiev is a specialty.

And there's still more—**four days in "wonderful, wonderful Copenhagen"** the fun-loving Danes' cosmopolitan capital. It's Denmark's largest city—a friendly happy place of spires and towers and winding streets.

The bright and attractive centrally located Sheraton-Copenhagen Hotel will greet you warmly with every comfort and convenience. Enjoy the superb view from the hotel's rooftop panoramic bar. Or dine leisurely in the King's Court dining room where international cuisine is the specialty.

The Danes are genial hosts—bars never close and the food is wonderful and all too plentiful. The uniquely Danish version of smorgasbord features over 200 varieties of delicious open-face sandwiches—each a meal in itself. Don't pass up the cheese, seafood or the infinite variety of pastries—they're all national specialties.

You'll revel in the carefree carnival atmosphere of Copenhagen's famed Tivoli Gardens.

Lighthearted adventure enchants you in this Danish fairyland . . . a world of tiny thatched roof cottages with storks nesting on chimney tops. A country of moated Renaissance castles like "Hamlet's" Elsinore Castle. You'll fall in love with the little Mermaid, perched on a rock, gazing out to sea. She symbolizes all that is Copenhagen and Scandinavia—a smorgasbord of everything progressive, prosperous, peaceful, bright and exquisite. Scandinavia is more than a place—it's a frame of mind, a philosophy—a way of life. You're in Hans Christian Andersen's childhood fantasy world where all your holiday dreams come true.

Travel through the **oldest kingdom in Europe**—Vikingland. Sparkling, clean, majestic—no wonder the Vikings lived here.

The Scandinavian Adventure can give you all this—in a completely new concept of travel that stretches vacation dollars farther. And, there is absolutely no regimentation on this luxury carefree vacation.

If you have not yet sent in your reservations for our Scandinavian Adventure, do so right away. Or contact the Ohio State Medical Association for any additional information you may need. Space is limited, so make your reservations now. We don't want to leave without you.

Pre-Sate®
(chlorphentermine HCl)
CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
Full information available on request.

WARNER-CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

for the practical generation

Pre-Sate®

(chlorphentermine HCl)



the trend is toward our kind of anorectic

Not a controlled drug under the Comprehensive Drug Abuse Prevention and Control Act

- low potential for abuse
- less CNS stimulation than with d-amphetamine or phenmetrazine

Effective anorectic adjunct to your program of caloric restriction and diet re-education

- weight loss comparable to d-amphetamine and phenmetrazine, superior to placebo
- convenient one-a-day dosage

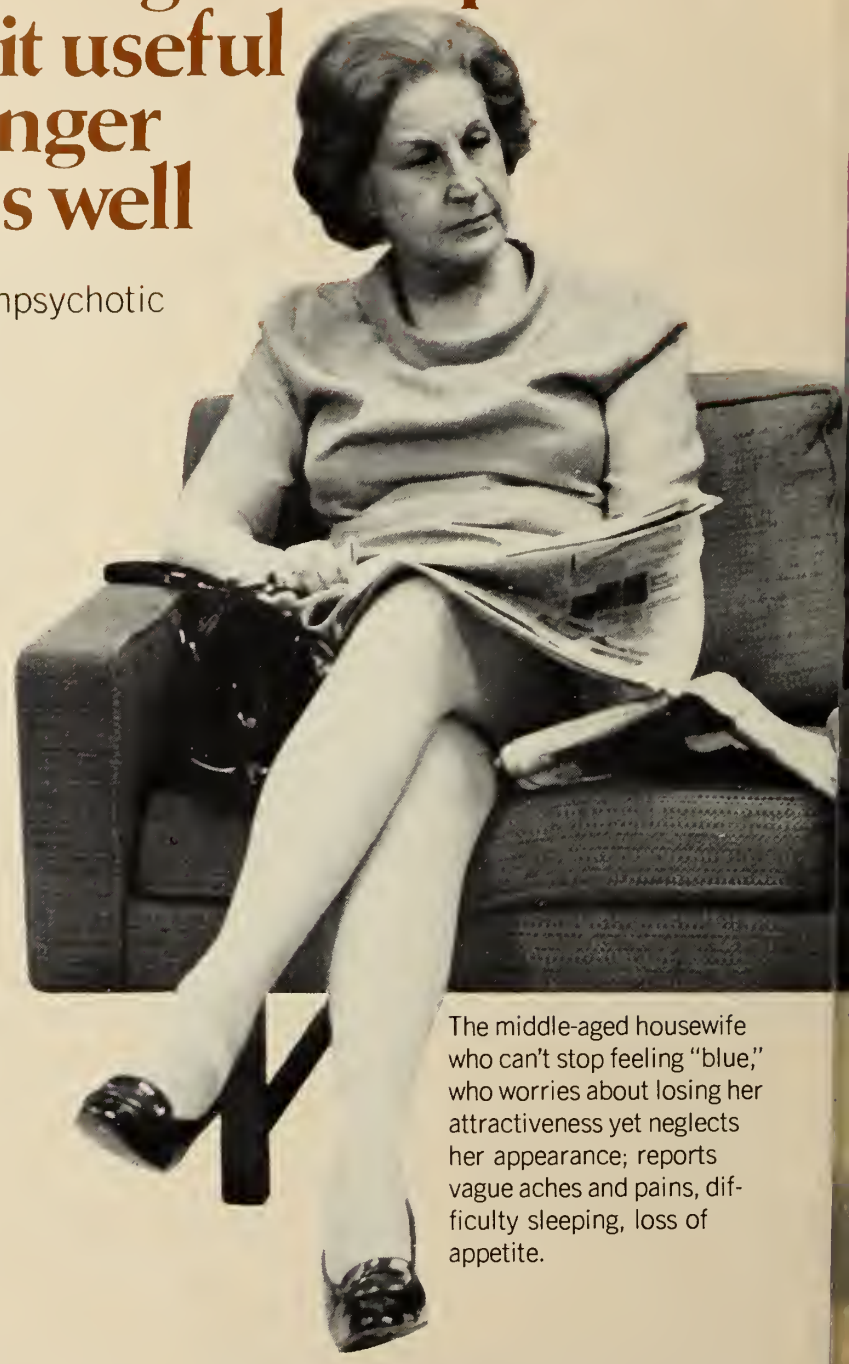
FR-GP-21-B/W

Pre-Sate® (chlorphentermine HCl)...the increasingly practical appetite suppressant



What makes 'Deprol' useful for depressed geriatric patients... makes it useful for younger patients as well

- helps ease mild to moderate nonpsychotic depression *and* related anxiety
- helps assure a good night's rest



The middle-aged housewife who can't stop feeling "blue," who worries about losing her attractiveness yet neglects her appearance; reports vague aches and pains, difficulty sleeping, loss of appetite.

INDICATIONS: Useful in the management of depression, both acute (reactive) and chronic; particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination; also useful for management of depression and associated anxiety accompanying or related to organic illnesses.
CONTRAINDICATIONS: Benactyzine hydrochloride: Glaucoma and previous allergic or idiosyncratic reactions to benactyzine hydrochloride or related compounds. **Meprobamate:** Acute intermittent porphyria and allergic or idiosyncratic reactions to meprobamate or related compounds such as carisoprodol, mebutamate, tybamate, carbromal.
WARNINGS: The following information on meprobamate pertains to 'Deprol' (meprobamate + benactyzine hydrochloride): **Meprobamate:** *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, then gradually withdraw. *Potentially Hazardous Tasks:* Drivin a motor vehicle or operating machinery. *Additive Effects:* Possible add tive effects between meprobamate, alcohol, and other CNS depressant or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established weigh potential benefits against potential hazards in pregnancy, nursin mothers, or women of childbearing potential. Animal data at five time the maximum recommended human dose show reduction in litter siz due to resorption. Meprobamate appears in umbilical cord blood at c near maternal plasma levels, and in breast milk at levels 2-4 times tha of maternal plasma. *Children Under Six:* Drug not recommended.
PRECAUTIONS: Meprobamate: To avoid oversedation, use lowest effe tive dose, particularly in elderly and/or debilitated patients. Consider pc sibility of suicide attempts; dispense least amount of drug feasible at ar one time. To avoid excess accumulation, use caution in patients with co promised liver or kidney function. Meprobamate may precipitate seizure in epileptics.
ADVERSE REACTIONS: Nausea, dry mouth, other g.i. symptoms; sy cope; one case each of severe nervousness and loss of power of conce tration. The following side effects, which have occurred after administratic of its components alone, have either occurred or might occur when th combination is taken. **Benactyzine hydrochloride:** Benactyzine hydr chloride alone, particularly in high dosage, may produce dizziness, thoug blocking, a sense of depersonalization, aggravation of anxiety, or dist

When mild depression and associated anxiety interfere with living

DEPROL®

(meprobamate 400 mg + benactyzine hydrochloride 1 mg)



The junior executive crushed by his repeated failure to be promoted and anxious about the future; complains to you of listlessness, early-morning awakening.

The young widow whose grief has persisted too long, is pessimistic and fearful about what lies ahead, has lost interest in everything; is preoccupied with vague physical ailments, has crying spells.

ance of sleep patterns, and a subjective feeling of muscle relaxation. here may also be anticholinergic effects such as blurred vision, dryness f mouth, or failure of visual accommodation. Other reported side effects ave included gastric distress, allergic response, ataxia, and euphoria. **Meprobamate:** *Central Nervous System:* Drowsiness, ataxia, dizziness, lurred speech, headache, vertigo, weakness, paresthesias, impairment of isual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: tchy, urticarial, or erythematous maculopapular rash (generalized or onfined to groin). Others: leukopenia, acute nonthrombocytopenic purura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopahy, fever, fixed drug eruption with cross reaction to carisoprodol, and ross sensitivity between meprobamate/mebutamate and meprobamate/arbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioeurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus rednisolone). Stop drug, treat symptomatically (e.g., possible use of pinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.

USUAL ADULT DOSAGE: One tablet three or four times daily, which may be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended.

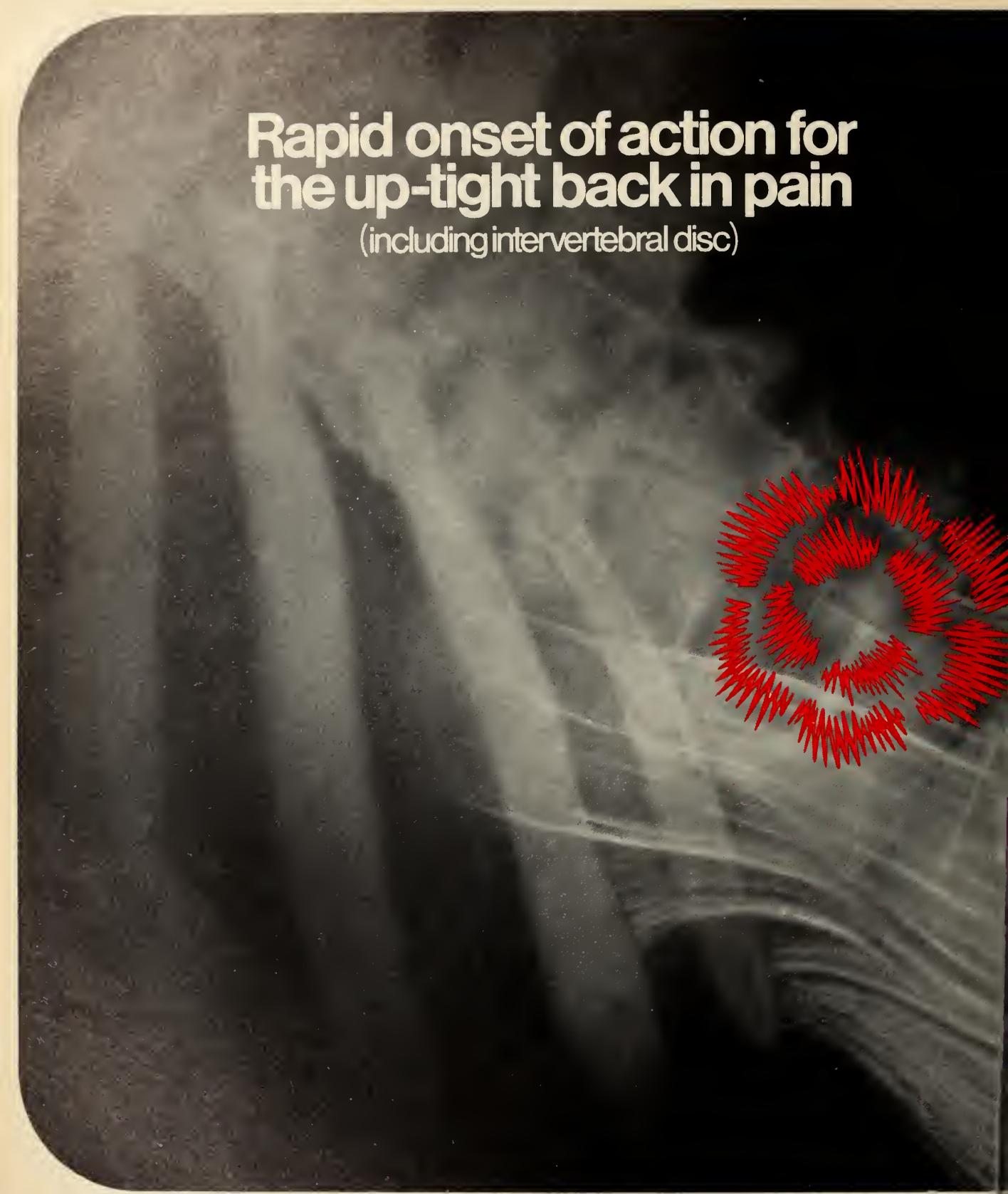
OVERDOSAGE: Overdosage of 'Deprol' (meprobamate + benactyzine hydrochloride) has not differed substantially from meprobamate overdosage: **Meprobamate:** Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10/71

Before prescribing, consult package circular or latest PDR information.

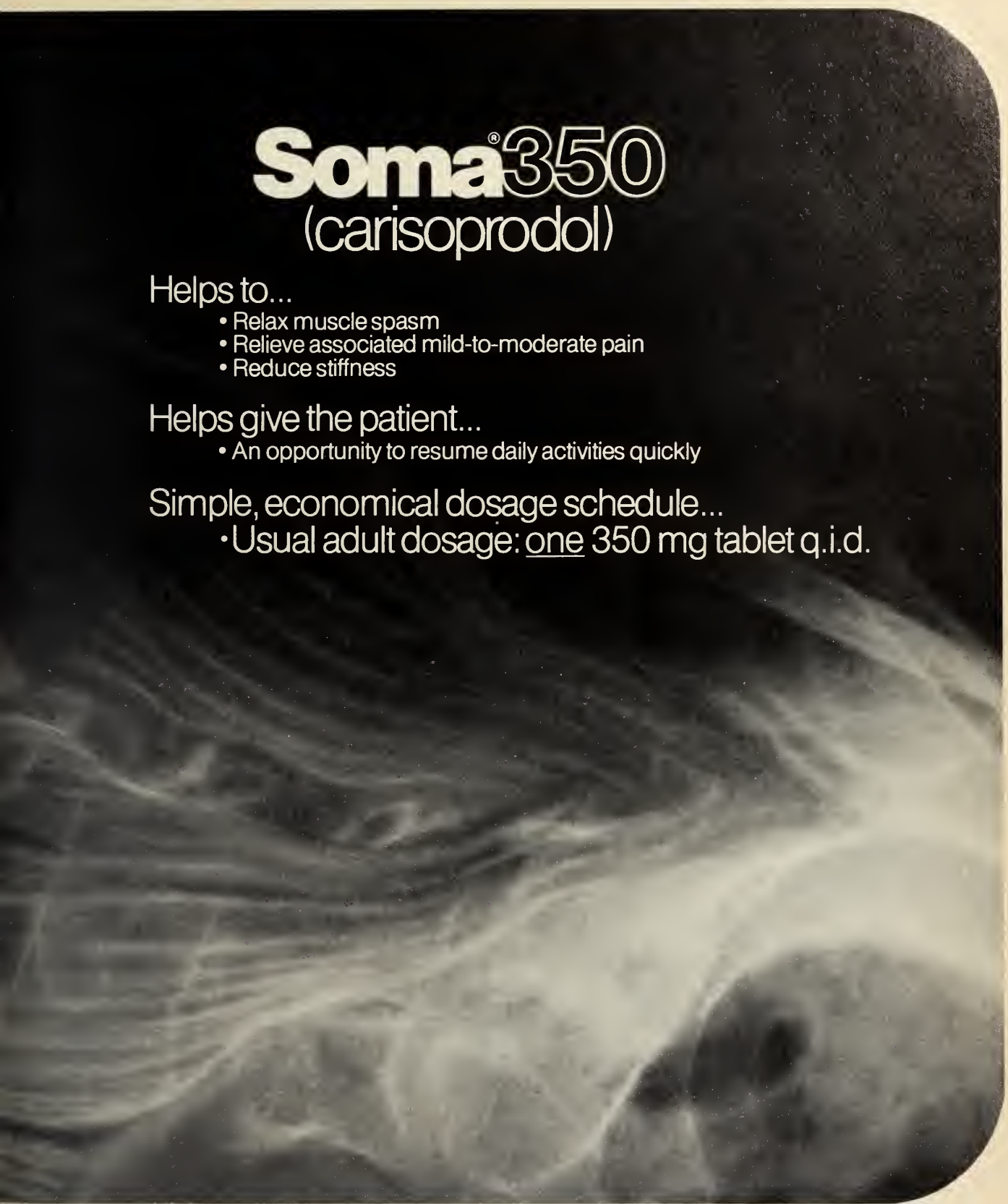
WALLACE PHARMACEUTICALS, Cranbury, N.J. 08512

Rapid onset of action for the up-tight back in pain

(including intervertebral disc)



Indications: For symptomatic relief in conditions characterized by skeletal muscle spasm and mild to moderate pain.
Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.
Warnings: *Idiosyncratic Reactions:* Rarely, first dose has been followed by extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion, disorientation. Symptoms usually subside during the next several hours. Supportive and symptomatic therapy, including hospitalization, may be necessary. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. *Children Under Five:* Drug not recommended. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between carisoprodol, alcohol, and other CNS depressants or psychotropic drugs. *Drug Dependence:* Use cautiously in addiction-prone patients.
Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.
Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia. *Allergic or Idiosyncratic* Usually seen after 1-4 doses in patients not previously exposed e.g., rash, erythema multiforme, pruritus, eosinophilia, fixed dru



eruption with cross reaction to meprobamate. More severe manifestations: asthma, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension, anaphylactoid shock. Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Cardiovascular:* Tachycardia, postural hypotension, facial flushing. *Gastrointestinal:* Nausea, vomiting, hiccup, epigastric distress. *Hematologic:* Leukopenia and pancytopenia (on carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. Overdosage of carisoprodol plus alcohol or other CNS depressants or psychotropic drugs can be additive. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10/71

WALLACE PHARMACEUTICALS /Cranbury, N.J. 08512

if skin is infected, or open to infection...

choose the topicals that give your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

OSMA-BWC's Success Story

The Ohio State Medical Association's Committee on Workmen's Compensation recently reported the successful operation of the Ohio Bureau of Workmen's Compensation's — OSMA "usual, customary and reasonable" fee program over a period of six years. This report was made to The OSMA Council and members of The Council felt that this "success story" should be called to the attention of physicians throughout the state.

The Bureau of Workmen's Compensation put the "usual, customary, and reasonable" fee for physicians' services into effect in October, 1965, discarding its previously used fixed fee schedule. Under the program, a physician who provides professional medical services to an injured workman, receives his usual, customary and reasonable fee.

At the time the new program was instituted, the Bureau of Workmen's Compensation and the Ohio State Medical Association agreed to a procedure for referral of cases. Under the agreement, when the Bureau feels that the "usual, customary and reasonable" fee in a particular case should be reviewed, the case is referred to the appropriate County Medical Society through the OSMA.

The success of the program is reflected in the remarkedly small number of cases referred for review. In view of the fact that well over a million BWC claims for physicians' services were processed during this period, the following information on claims referred for review is most significant.

Since October 1965, 201 cases have been referred for a recommendation from the County Medical Society on the "reasonableness" of the fee. The County Medical Societies recommended that 100 were "usual, customary and reasonable." 63 were reduced, 34 cases were settled without specific county medical society recommendation. Four cases are pending.

Ohio license plates for 1973 will bear the legend "Seat Belts Fastened?" making Ohio the first state in the nation to imprint a safety slogan on official vehicle license plates, the Ohio Department of Highway Safety announced.

HARDING HOSPITAL
WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

* 125 In-patient beds —
* Day Hospital program —
* Full time attending staff of psychiatrists —
* Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
* Qualified staff of psychologists —
* Social Service department —
* Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
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George T. Harding, M.D.
Medical Director

Donald L. Hanson
Administrator

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.

An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonarrhaeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonarrhaeae.*

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for a least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. ganorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

High cure rate:* 96% of 571 males, 95% of 294 females
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

globin; hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Continuing Education Opportunities for Physicians in Ohio

March

Orthopaedic Rehabilitation—At the Hollenden House, Cleveland, March 13-15; sponsored by the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Illinois 60611.

Maxillofacial Trauma — Workshop sponsored by the American Academy of Facial Plastic and Reconstructive Surgery and the University of Cincinnati Medical Center; March 13-16; contact Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati 45219.

Diagnosis and Management of Hypoglycemia —Trumbull Memorial Hospital, Warren; noon program, March 14; to be presented by James Craig, M.D., and or Bernard Landau, M.D., of Case Western Reserve University.

Infectious Diseases—OSU College of Medicine, March 14; contact Center for Continuing Medical Education at the College.

Some Aspects of Diuretic Management—Fort Steuben Academy of Medicine, March 14, at 8:15 p.m., Fort Steuben Motor Hotel, Steubenville; guest speaker, E. Gordon Margolin, M.D., well-known Cincinnati specialist in internal medicine, renal diseases, and electrolytes.

Infectious Diseases: Common Difficult Problems in Diagnosis and Therapy — Ohio State University Center for Continuing Medical Education; at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, March 15.

Detection of Australian Antigen—Cleveland Clinic Educational Foundation, March 15-16; co-sponsored by the American Society of Clinical Pathologists.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Seventh Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 15-16; Marvin J. Sakol, M.D., coordinator.

Advances in Urology—Cleveland Clinic Educational Foundation, March 15-16.

Veterans Administration Hospital Annual Seminar—VA Hospital, Cincinnati, March 16; Gene Conway, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

G. I. Bleeding—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 17.

Diagnosis and Repair of Facial Fractures — Medical Center, University of Cincinnati, March 20-24; Donald A. Shumrick, M.D., director; contact Office of CONMED, 114 Medical College Building, Eden and Bethesda Avenues, Cincinnati 45219.

A Lipid Tutorial—Cleveland Clinic Educational Foundation, March 23-24.

Practical Laboratory Chemistry, Manual and Automated—Cleveland Clinic Educational Foundation, March 23-24.

Examination of the Newborn; Cardinal Points of the Examination — St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 24.

(Continued on Page 239)


Pink isn't exactly his color,
but he loves it for a change.
WinGel®
aluminum-magnesium hydroxides
mint-flavored antacid liquid and tablets
For your ulcer and ulcer-prone patients...
a refreshing break from the
boring sameness of white antacids.
• pleasing mint flavor
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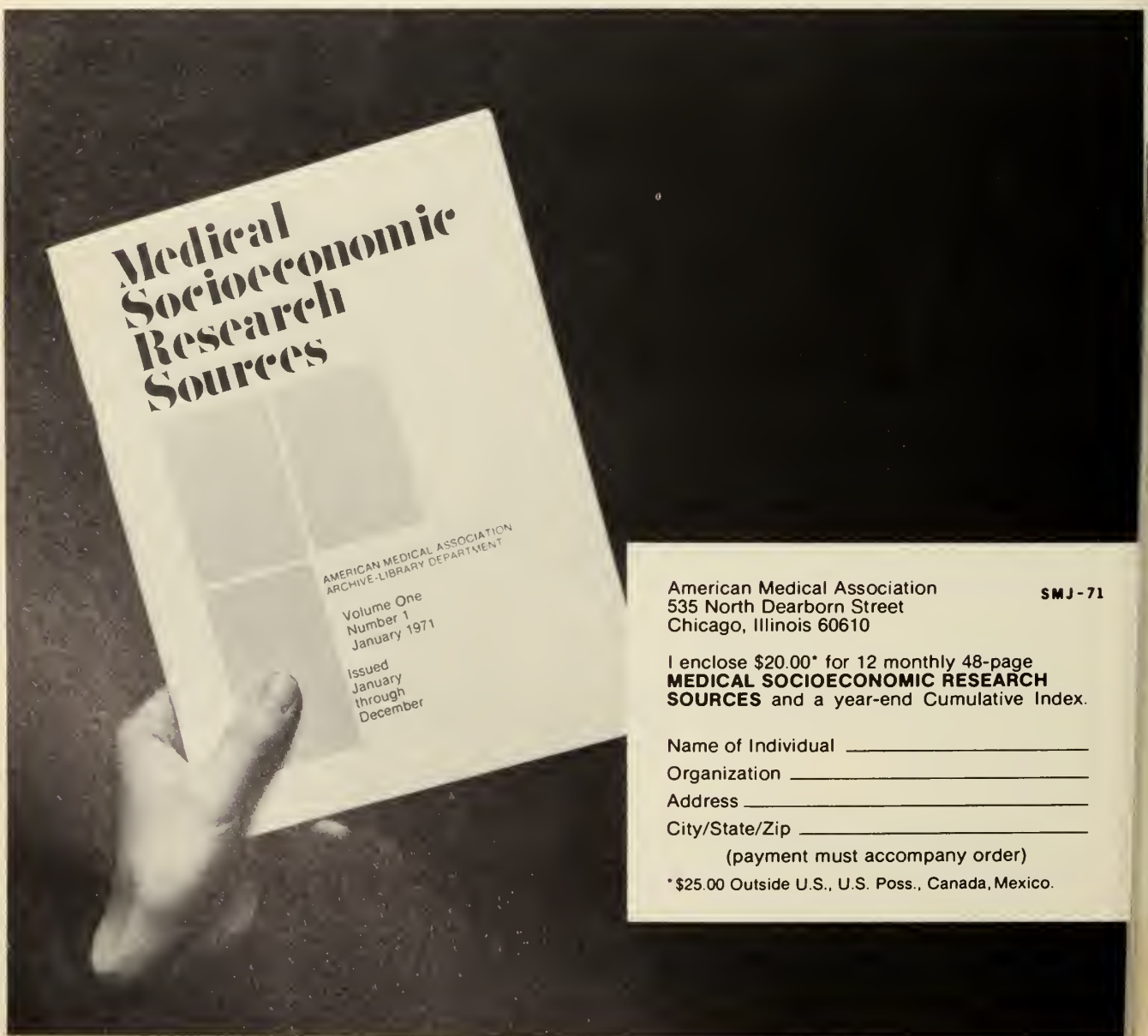
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Educational Opportunities in Ohio — *Continued*

Huntington Chorea Association—OSU College of Medicine, Columbus, March 26-29; contact Center for Continuing Medical Education, at the University.

Isotopes in Clinical Medicine (Pharmacology Series) — Youngstown Hospital Association, March 27.

ENT Emergencies—St. Elizabeth Hospital, Youngstown, 8-9 a.m., March 31.

April

Cancer Symposium — Ohio State University College of Medicine, April 5.

Diagnostic Immunology — Cleveland Clinic Educational Foundation, April 5-6.

Immunization Program Preview—St. Elizabeth Hospital, Youngstown, April 7, 8:00 to 9:00 a.m.; Dr. B. Brucoli.

Chemotherapy in the Patient with Incurable Cancer—Youngstown Hospital Association, South Unit, April 10, 4:00 p.m.; Drs. W. D. Loeser and H. Hoffler.

Hyperthyroidism—Trumbull Memorial Hospital, Warren, April 11, 12:00 noon to 1:00 p.m.; speaker, Dr. Richard P. Levy, Case Western Reserve University.

Annual Trauma Meeting — Fort Steuben Academy of Medicine, Fort Steuben Motor Hotel, Steubenville, April 11, 8:15 p.m. Subject, **Total Hip Reconstruction,** with guest speaker Dr. Charles M. Evarts, Cleveland.

Internal Medicine (Visiting Professor Program) — Akron City Hospital, 525 East Market Street, Akron, April 13-14; Dr. William Keith C. Morgan, West Virginia University School of Medicine.

Depression in Medical Practice—Ohio State University Department of Psychiatry, April 13-14, at Stouffer's University Inn, 3025 Olentangy River Road, Columbus; contact the Center for Continuing Medical Education at the OSU Medical Center.

Term Management of Acute Respiratory Failure — Cosponsored by the American College of Chest Physicians and the Cleveland Clinic, at the clinic; April 13-15.

What the GP Should Know About Anesthesia — St. Elizabeth Hospital, Youngstown; April 14, 8:00-9:00 a.m.; Dr. R. Richards.

Lederle Symposium on "Being a Physician in Our Time" — Ohio Academy of Family Physicians and Ohio State University College of Medicine, at the Sheraton-Columbus Motor Hotel, downtown Columbus, April 16.

A Day of Therapeutics — Akron City Hospital, 525 East Market Street, Akron; American Society for Clinical Pharmacology and Therapeutics, April 19.

Advances in Orthopaedic Surgery — Cleveland Clinic Educational Foundation, April 19-20.

The Hospital-Wide Coronary Care System — Sponsored by the American College of Cardiology, at Good Samaritan Hospital, Dayton, April 19-20.

Estrogens and Their Abuses — St. Elizabeth Hospital, Youngstown, April 21, 8:00-9:00 a.m.; Dr. L. Alexander.

New Antibiotics — Youngstown Hospital Association, South Unit; April 24; 4:00 p.m.; Drs. G. A. Butcher and S. A. Khuddus.

New Concepts and Practices in Diseases of the Colon and Rectum — Cleveland Clinic Educational Foundation, April 26-27.

The Low Back Problem; Proper Examination Explained — St. Elizabeth Hospital, Youngstown; April 28, 8:00-9:00 a.m.; Dr. J. J. Sofranec.

Introductory Course in Nuclear Medicine for Physicians — Dates on request to Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

May

Seventh Annual Dickson, Duncan, Rainbow, Reich Orthopaedic Lectureships — At St. Luke's Hospital, 2065 Adelbert Road, Cleveland; May 1-2; guest lecturers, Drs. R. L. Cruess, R. B. Duthie, W. W. Lovell, and H. E. Pedersen; program sponsored by the Cleveland Orthopaedic Club in conjunction with Orthopaedic Departments of Cleveland Clinic, Mt. Sinai, St. Luke's and University Hospitals; for reservations contact Dr. S. Nahigian, 3461 Warrensville Center Road, Cleveland 44122.

Arteriosclerosis and the Anesthesiologist — Cleveland Clinic Educational Foundation, May 3-4.

Recent Advances in Abdominal Surgery — At Shriners Burns Institute, Cincinnati, May 3-4; Dr. William A. Altemeier, director; contact Office of CONMED, Eden and Bethesda Avenues, Cincinnati 45219.

(Continued on Page 242)







T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

Synthroid®
(sodium levothyroxine)

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY.

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

Choose the Smooth Road ...to thyroid replacement therapy







WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

ery simple. T_3 costs more to make ynthetically than does T_4. So it is conomically necessary for a ynthetic thyroid medication ontaining T_3 to cost more than ne containing T_4 alone. Synthetic ombinations cost patients nearly 0% more than SYNTHROID[3] ecause the T_3 costs more to start ith; also there is the additional xpense of formulating a tablet ontaining two active ingredients.

American Druggist BLUEBOOK, Merch, 1971.

KNOWLEDGE OF THE '70's CHALLENGES CUSTOMS CONCERNING DESICCATED THYROID DRUGS.

In the past, desiccated thyroid produced from animal glands was considered "good, and cheap." We now know that improved products are available and the price difference has narrowed to the point of being inconsequential. (SYNTHROID, for instance, costs patients about a penny a day more than brands of desiccated thyroid.)

What does this additional $3.65 a year buy the patient? Quite a bit in terms of quality, reliability and service.

SWITCHING PATIENTS TO SYNTHROID IS EASY.

Switching present patients to SYNTHROID (or starting new ones) is a simple matter. SYNTHROID is available in the widest range of dosage strengths of any thyroid drug. Seven scored, color-coded tablet strengths are available plus a lyophilized injectable form for emergency or postoperative uses.

RESPONSE, RELIABILITY, SERVICE—COMPARISON OF FIVE PARAMETERS

PARAMETERS	DESICCATED THYROID U.S.P.	SYNTHROID® (sodium levothyroxine)
SOURCE OF HORMONE	Animei glends (swine, sheep, cows). Hormone content of glends end retio of T_3-T_4 veries by type of animal, season in which glend is hervested, end diet of enimal.[1,2,3,4,5]	Syntheticelly derived pure crystalline hormone. Because no animal protein is present, no objectionable odor occurs upon eging.
GENERAL ASSAY TECHNIQUE	"its mejor disedvantage is Inedequate standerdization of hormonei content."[8]	Uniike desicceted thyroid U.S.P., thyroxine does not require biologic stendardizetion to estebiish its potency.[2,6] Crystelline T_4 is used. Purity is verified by peper chrometography. Content of tablets is standerdized by weight.
CLINICAL RESPONSE	"T_3 end T_4 retio veries eccording to gland source. Fiuctuetions In response cen occur. Potency can vary."[3]	"Sodium levothyroxine hes been extensively used with setisfaction end is widely held to be superior to (desiccated) thyroid."[7] "There ere well documented exemples of patients who failed to respond satisfectorily to desiccated thyroid but subsequently responded to (sodium-1) thyroxine."[4]
PREDICTABILITY	Feiiure of thyroid U.S.P. treated patients to show ciinicai Improvement end/or leck of correiation in ciinicel findings to thyroid function test results hes been frequently discussed in the litereture.[8,9,10,11,12,13,14,15,16] Regardless of which factor or fectors accounts for this phenomenon the fact remeins thet discrepancies do occur.	Test results predictably eleveted. ". . . orel potency of this meterlai is attested to by a uniformly good ciinicei response corroborated by a prompt and susteined increase in the serum PBi ieveis."[16]

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16. Bartuska, D. G., et al.: Desiccated thyroid U.S.P. or sodium l-thyroxine?, J. Amer. Med. Women's Assn., *21*:137-9, 1966.

See next pages for prescribing information.







PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3. In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling[2]. T_4 does convert to T_3, though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

CONSIDERATE LONG-TERM THERAPY FOR THE PATIENT.

Predictable patient response, of course, is more important than price. You do get complete clinical response with the single-entity synthetic, SYNTHROID. And, at a reasonable cost to the patient. In some short term situations, T_3 drugs can be useful but, in long term therapy, the smooth road provided by SYNTHROID may be the better route.

SYNTHROID, with its smooth road to complete thyroid replacement therapy, has been selected for more patients in the United States and Canada than any other brand of thyroid medication.

2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) In Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

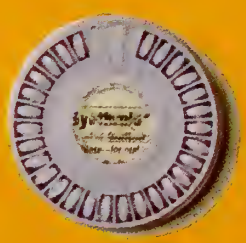
Choose the Smooth Road ...to thyroid replacement therapy



0.05 mg.



0.1 mg.



0.15 mg.



0.2 mg.

FREE TAB-MINDER medicat dispensers—color-coded in 4 d age strengths—get patients of a good start and encourage r ular habit patterns. Contain fe 4-weeks' supply of SYNTHRO and are reusable for maintena e dosage.

APPROXIMATE DOSAGE EQUIVALENTS*

			Animal Gland		
CYTOMEL (Sodium liothyronine) Synthetic T_3	EUTHROID** (Liotrix) Synthetic T_3-T_4	THYROLAR*** (Liotrix) Synthetic T_3-T_4	Desiccated (Thyroid, USP) Cow, sheep or hog thyroid	PROLOID (thyroglobulin) Frozen hog thyroid	SYNTHROID (Sodium levothyroxine) Synthetic T_4
Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

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*Equivalents shown are chemical, and do not take into consideration individual patient variables. Clinical effect is approximate and should be monitored when converting a patient to SYNTHROID. This is particularly important in patients previously on desiccated thyroid. In these patients, lower doses of SYNTHROID may produce the same metabolic effect.

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Renal Hypertension Clinic — RMP, University of Pittsburgh — St. Elizabeth Hospital, Youngstown; May 12, 8:00-9:00 a.m.

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Flexible Viewing and Photography of the Stomach and Duodenum — Youngstown Hospital Association, South Unit, May 15, 4:00 p.m.; Drs. D. B. Brown and S. S. Guleria.

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Fourteenth Annual Refresher Course in Diagnostic Roentgenology — Department of Radiology, University of Cincinnati College of Medicine; Dr. Benjamin Felson, director; May 30-June 3; includes nuclear medicine, radiation physics and radiation therapy; contact Dr. Harold B. Spitz, Department of Radiology, Cincinnati General Hospital, Cincinnati 45229.

June

Stroke and Rehabilitation — St. Elizabeth Hospital, Youngstown; June 2, 8:00-9:00 a.m.; Drs. R. Gilliland and A. Riberi.

Granulomatous and Nongranulomatous Colitis — Youngstown Hospital Association, South Unit, June 5; Drs. D. B. Brown and Y. P. Sheth.

Symposium on Microneurosurgery — Departments of Neurosurgery, Good Samaritan and Christ Hospitals, Cincinnati, June 8-10; distinguished guest and local faculty; Contact Dr. John M. Tew, Jr., 506 Oak Street, Cincinnati 45219.

Anxiety Reactions and Their Management — St. Elizabeth Hospital, Youngstown; June 9, 8:00-9:00 a.m.; Dr. F. Gelbman.

Modern Concepts in Clinical Cardiology — An American College of Physicians postgraduate course; University of Cincinnati College of Medicine, June 12-16; director, Noble O. Fowler, M.D.; codirector, Robert J. Adolph, M.D.

Management of Hypertension — St. Elizabeth Hospital, Youngstown; June 16, 8:00-9:00 a.m.; Dr. W. Bunn.

Drug Induced Thrombocytopenia and Hemolytic Anemia — Youngstown Hospital Association, South Unit, June 19; Drs. L. M. Pass and N. A. Pappas.

Worms and Man — St. Elizabeth Hospital, Youngstown, June 23, 8:00-9:00 a.m.; Drs. G. Canatsey and P. Van Zandt.

August

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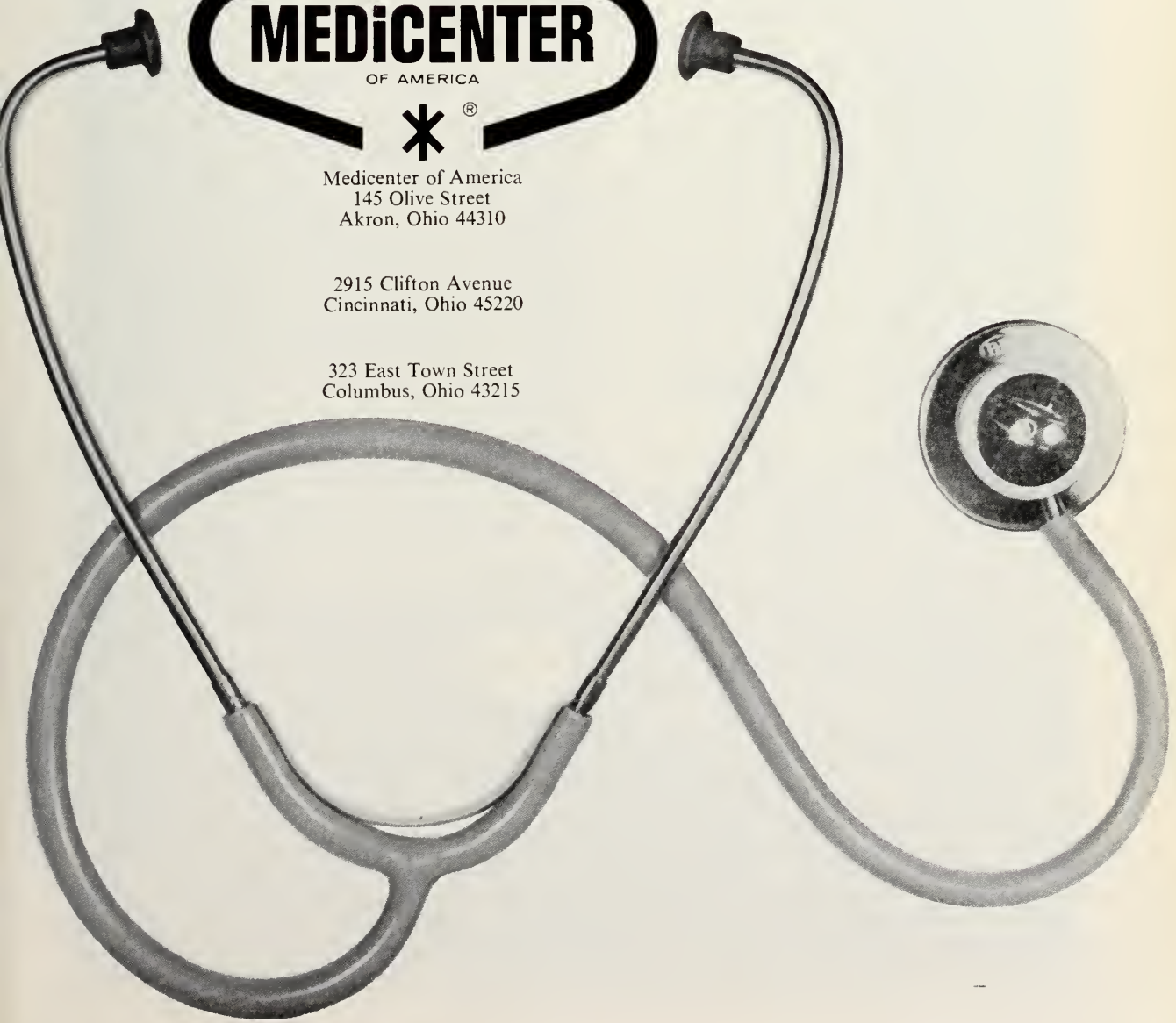
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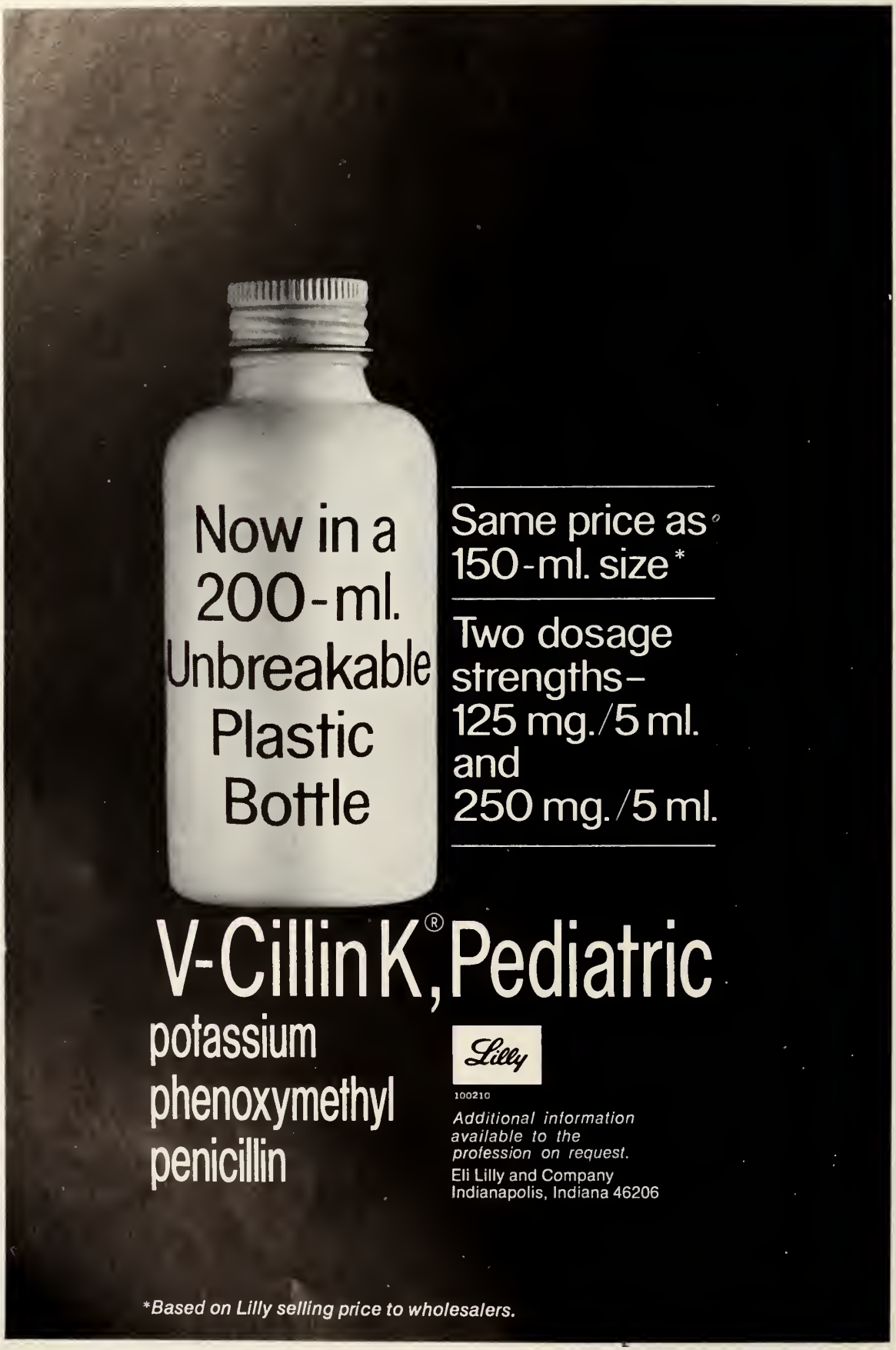
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Clinical & Scientific Features



VOLUME 68 MARCH 1972 NUMBER 3

A Study of Twelve Applicants for Transsexual Surgery

BYRON STINSON, M.D.

IN THE SUMMER OF 1969, a patient was admitted to The Ohio State University Hospitals seeking sex transformation surgery. The interest and sympathy aroused by his plight led to a study of the problem by the divisions of plastic surgery and endocrinology, and the department of psychiatry. A protocol for the evaluation of such cases was established and legal advice was obtained to examine the status of transsexual surgery in the State of Ohio. While these preliminaries were in process, 11 other patients presented themselves for consideration (although no hope for surgery was held out to them). An attempt was made to set up an estrogen treatment program which floundered. At the present time there is no prospect of offering either surgical or endocrine treatment to these patients at The Ohio State University Hospitals.

The Author

• **Dr. Stinson, Columbus, is Assistant Professor, Department of Psychiatry, The Ohio State University College of Medicine.**

Definition of the Problem

The major problem in dealing with candidates for sex transformation surgery is defining "transsexualism." Socarides[1] comments, "It should be noted that transsexualism is neither a diagnosis nor is it given a place in the Psychiatric nomenclature." About all that characterizes the syndrome is "the *wish* to change sex." In an effort to reach an etiologic definition, Stoller[2] postulates, ". . . it must have powerful genetic or hormonal roots because the commitment to change of sex is so strong and often has started so early in childhood that no psychodynamic generalizations explain the clinical picture satisfactorily." Benjamin[3] claims that 30 percent of his patients show "some sort" of biologic abnormality. These considerations are in keeping with the recent work of Margolese, as reported in *Medical World News,* April 23, 1971, p. 4. He showed the andosterone/etiocholanolone ratio of 80 percent of 15 homosexual patients to be in the range of normal for females. It is believable that an hormonal spectrum provides the substrate of both the anatomic and psychosexual

Submitted June 23, 1971.

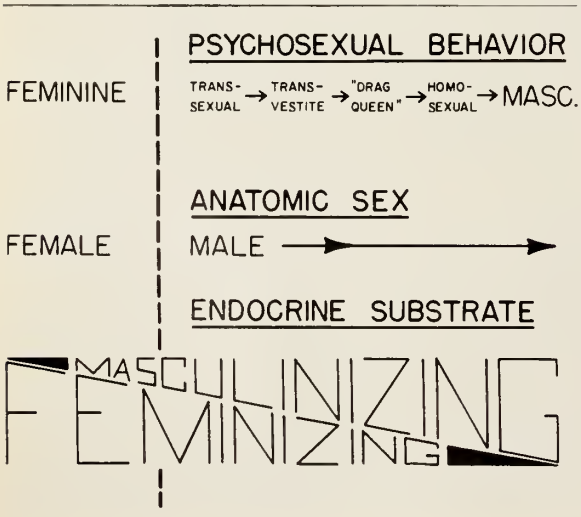
identities. Since the anatomic distinction between the male and female is almost exactly a plus-minus situation, while psychosexual behavior is continuously distributed, much confusion arises in switching between these frames of reference. These relationships are shown in Table 1.

Hastings[4] has invoked the idea of "imprinting failure" as demonstrated by Lorenz[5] in his greylag geese to explain the failure of normal masculine rearing "to take" in anatomically normal males. Gregory speaks of this phenomenon, which occurs prior to the age of 3 years, as "psychosexual inversion." Behaviorwise, Stoller[6] presents the idea of an intensive symbiotic relationship between the male infant and his mother as an etiologic factor.

Unsatisfying as these definitions are, Stoller's[6] global definition is even less satisfying: "I consider a transsexual to be a person who feels himself (consciously and unconsciously) to belong to the opposite sex while not denying his sexual anatomy. . . . He is to be differentiated—and can easily be clinically differentiated—from the great masses of people who have identifications with members of the opposite sex and who reveal these identifications in areas of behavior, but who do not so unequivocally believe themselves to be members of the opposite sex."

If surgery were always beneficial or always harmful there would be no need to agonize about definitions or differential diagnosis. However, surgery has proved to be a mixed blessing. Benjamin[3] reports a number of patients, 34 of 40 (rated "satisfactory" on a satisfactory-doubtful-unsatisfactory scale), who have reaped rewards of improved self-esteem and more effective functioning after sex transformation surgery. But Socarides[5] and Meerloo[7] note some hair-raising failures. Since the surgical procedure is irreversible and the failures are so traumatizing, too much effort cannot be expended to insure proper selection.

Table 1. Illustrating Gross Relationship Between Psychosexual Behavior, Anatomic Sex, and an Hypothesized Endocrine Substrate. Also Presenting a Rough Spectrum of Psychosexual Behavior in the Male.



Randell[8] introduces the idea of compulsive behavior as a dynamic which motivates these patients to seek surgery, "With compulsive drive they pursue their goal of surgical remodeling of these sexual characteristics in the pattern of an obsessive/compulsive neurosis." Continuing the compulsion theme, Pauly[9] indicates, "it is characteristic for the true transsexual to push beyond the limits of what is possible and to settle for nothing less than what is conceivable." Hastings[4] seconds this notion, "The patient who has minor defects such as a nose that may be crooked, a larynx that may be prominent, or ears that he regards as unusually large, often is preoccupied with thought of surgical correction of these."

Even the proponents of surgical treatment have serious concerns about its widespread application. Randell[8] warns surgeons to "exclude ruthlessly all who are too maladjusted or constitutionally predisposed to psychiatric illness" and Stoller[2] cautions "the true transsexual is extremely rare."

Hypothesis

The patients in this study seem more like those of Randell than those of Stoller. If transsexuals are rare and patients applying for surgery are reasonably common, who, then, is seeking surgery? It was my initial impression that they were homosexuals with severe obsessive-compulsive neurosis. This is in keeping with an idea of Barnett,[10] "Repetitive, compulsive, and stereotyped sexual behavior, like compulsive masturbation and compulsive promiscuity (heterosexual and homosexual), is a frequent obsessive-compulsive pattern."

The underlying dynamics appeared to be those of highly moralistic individuals with deep guilt feelings about their homosexuality. Kolb[11] sees "an overwhelming fear of intolerable impulses" lying at the root of all obsessive-compulsive reactions. Pomeroy [12] delineates the moralistic bind of the transsexual, "They appear to be rather rigid, moralistic, isolated people with, usually, rather low rates of overt sexual behavior but a very great fantasy life . . . homosexuality was so immoral to them that the only way they could have sex with males was to become a female." Stoller[6] points up the source of their anxiety in much the same light, ". . . directed very specifically against their 'dreadful' homosexuality and are so frightened because they have internalized society's fearful hatred of homosexuality."

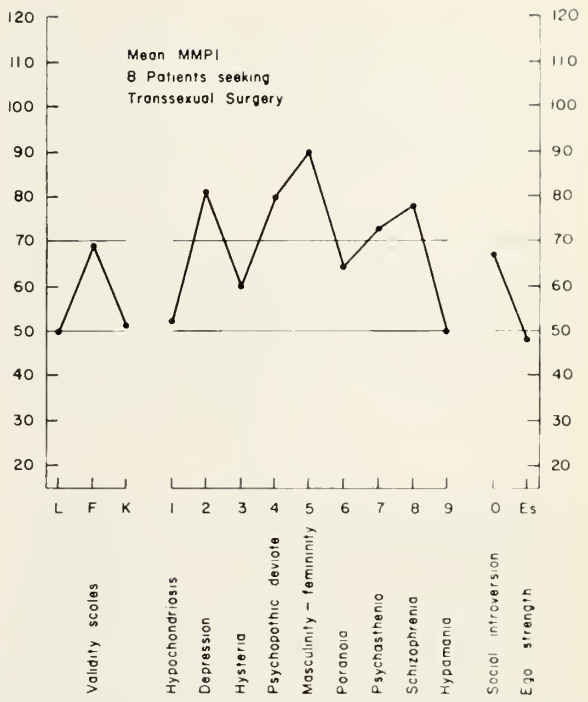
Randell[8] introduces another variation on this theme, "They felt after castration they would be

women and therefore no longer be homosexual." Obsessive-compulsive persons have the drive for punishment, atonement, and absolution—always just beyond their grasp. A phobia toward their genitalia develops. "To him his sex organs are sources of disgust and hate," according to Benjamin.[3]

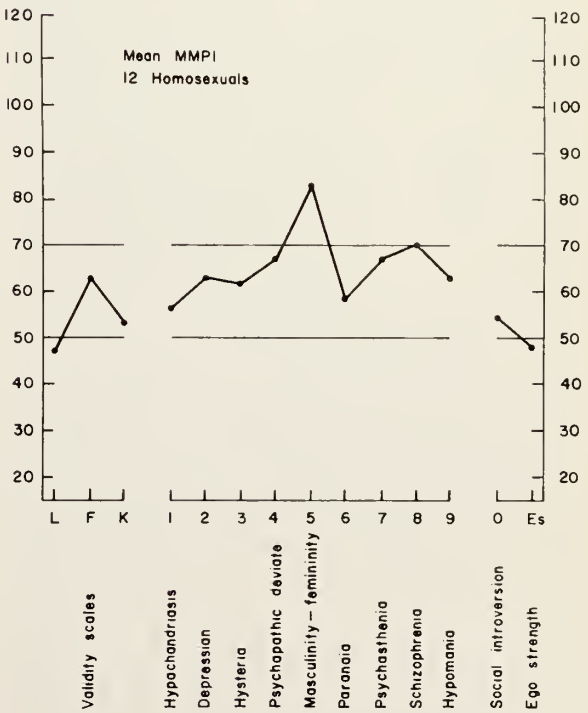
Consideration of the Minnesota Multiphasic Personality Index (MMPI) Data

In an effort to provide objective data in an area where the approach has been almost entirely intuitive, a comparison of the mean MMPIs of two groups of patients was made—applicants for transsexual surgery and socially functioning homosexuals. While there are objections to using MMPI profiles in this manner, Kangas remarked, "Mean MMPI profiles have an area of usefulness, especially when the psychopathology has not been washed out in the process—these are okay." Two groups of patients are compared, eight men seeking transsexual surgery and 12 practicing homosexuals (six of whom enjoy cross-dressing in the role of the "drag queen"). Three of the 12 transsexual applicants did not return to complete the psychological battery and one profile was omitted as invalid. (This patient admitted to being high on marijuana at the time he took the test.) The homosexuals were volunteers for another, unrelated study. They were reasonably well-adjusted, not seeking psychiatric care, and were simply being helpful.

Experienced interpreters read these profiles in the "blind." Since the mean profile was submitted as that of a single individual, the interpretation is presented in the singular. The mean age of the "transsexual" group is 30 years and the mean IQ (Shipley-Hartford) is 113. Typical comments on the "transsexual" profile (Attachment 1) are: There is a marked femininity of attitudes (one standard deviation more than the average female). There is a high probability of psychosexual inversion with overt homosexuality or other well-established sexual deviation. Also presented is a dominant problem with impulse control, rebellion toward authority figures, and disregard for social mores—especially in the psychosexual area. Despite these comments, this patient should not be looked upon as a carefree sexual psychopath, because he is showing depression, obsessive concern with his problem, and social isolation. Whether these indicators of subjective discomfort are a function of specific social consequences which have followed from impulsive acts or whether they ought to be understood as internal punishment he metes out to himself and which vies for psycho-



Attachment 1. The mean MMPI of eight "transsexual" candidates shows marked depression, impulsivity (Scale 4), feminine identification, bizarre thinking (Scale 8), and social introversion.



Attachment 2. The mean MMPI of 12 homosexuals shows evidence of strong feminine interests and richness of fantasy (Scale 8).

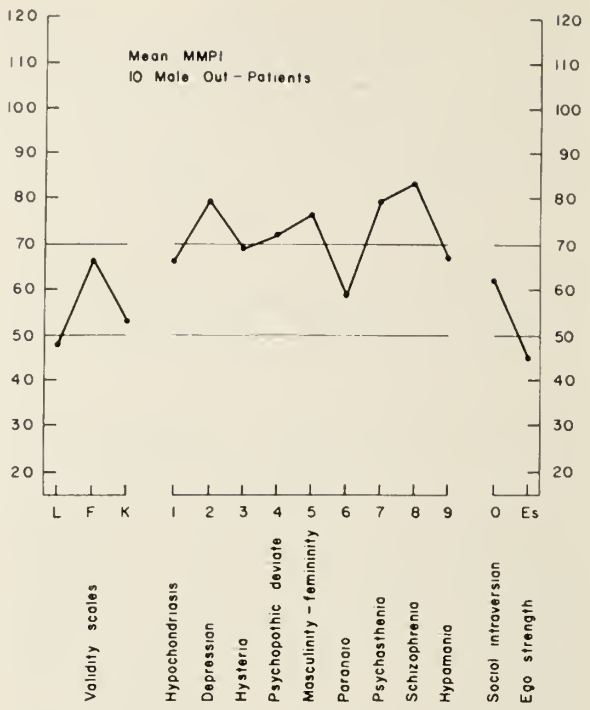
logical dominance with his impulses cannot be determined from this profile.

The mean age of the homosexual group (Attachment 2) is 24 years and the mean IQ (Shipley-Hartford) is 110. The interpretations of the homosexual profile suggest: The most characteristic finding is the femininity of attitude which corresponds closely with that of the average female and may be associated with overt homosexual behavior or other sexual deviation. While this patient may have worries about his masculinity, it is possible that his psychosexual conflicts are sublimated in aesthetic, cultural, and literary pursuits. The degree of psychopathology in this profile is much less intense than in the previous profile.

The third MMPI (Attachment 3) is included as a "control" and is the mean MMPI of ten randomly selected male outpatients who were seeking help at the Adult Psychiatric Clinic during the period of the present study, none of whom presented primarily with a psychosexual problem. The mean age is 24 years. (The mean IQ is unknown.) Examination of this tracing indicates this patient presents a more inhibited form of emotional disturbance than the other two. He is more likely to appear anxious, depressed, alienated, and to show signs of a schizoid personality.

The thesis that the applicants for transsexual surgery are simply obsessive-compulsive homosexuals is not borne out by the MMPI data. All three profiles display a 2-7-8-0 pattern, which is consistent with a degree of obsessive-compulsiveness. However, this is prominent only in the profile of the male outpatient "controls." In the "transsexual" profile the *impulsive* behavior (Scale 4) is much more marked than the *compulsive* behavior (Scale 7). At the risk of oversimplification, Figure 1 compares the impulsive-compulsive factors of the three groups. The high level of "disturbance" is apparent in the "transsexual" group and in the control sample.

If the data do not support a diagnosis of obsessive-compulsive neurosis in the case of the sex transformation applicants, do they suggest an alternative? The findings best fit under the old psychoanalytic concept of "character neurosis." This syndrome is described by Michaels,[13] "The impulsive neurotic character presents dormant psychopathic tendencies which are held in check by the compulsive neurotic components of his character. When these components predominate, the individual behaves like the severe compulsive neurotic, showing marked inhibition, feelings of guilt, ambivalence, doubts, and suffering." This tenuous balance between impulsive psychopathic characteristics and impulsive neurotic characteristics results from a weak super-ego. Stoller[6] seems to be right in his observation that "society's fearful



Attachment 3. The mean MMPI of ten random male outpatients shows anxiety, depression, and alienation — a schizoid-type personality.

hatred of homosexuality" is the source of their anxiety. Lacking internalized controls and a strong self-concept, these patients are at the mercy of cultural prohibitions against their homosexual

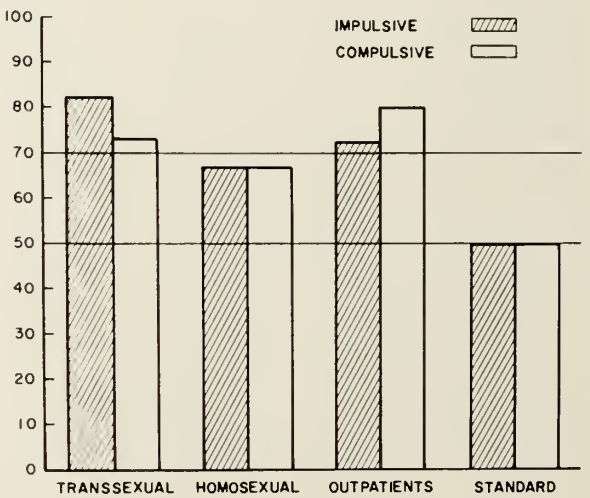


Fig. 1. Comparison of MMPI Scale 4 (impulsive tendencies) with Scale 7 (compulsive tendencies) and relationship of various groups in this respect. "Transsexuals" appear as most impulsive and male outpatients as most inhibited. Homosexual group shows evidence of conflict but compares reasonably well with standard for individuals of same age and sex.

feelings. The anxiety generated by this conflict is partially controlled by obsessive-compulsive activities.

Conclusions

The term "character neurosis" seems best to describe the psychopathology demonstrated by the patients seen in this study. In this syndrome, the impulsiveness is partially controlled by external cultural prohibitions which ultimately lead to obsessive-compulsive symptoms. Some measure of anxiety amelioration is gained when they become obsessed with the idea of being "a woman trapped in the body of a man." Complex rituals of cross-dressing, female mimicry, and seeking hormonal and surgical treatment afford them a compulsive outlet for their sense of despair.

They have been derided as "sissies" or scorned as "queers" ever since they can remember. As clumsy as were their first attempts at cross-dressing, they were amazed and heartened by the change in behavior they encountered. Suddenly they found themselves transformed into a gentle, more rewarding world. A patient dressed and behaving as an attractive young woman, remarked, "It was a good trip down on the bus today, everyone was so kind to me."

Newmen[14] describes another rewarding aspect of the transsexual phenomenon. "It is of interest to note that they were all reassured to discover that George was *not a homosexual.* The diagnosis of 'transsexual' provided an explanation for his feminine behavior and was, especially for the parents, psychologically relieving." A patient in this study writes, ". . . I assumed myself to be a *homo*sexual since I had never heard of *trans*sexual. . . . the *trans*sexual phenomenon has inspired me and given me new hope."

Despite some real psychological benefits of surgery, it appears that many who have been operated on continue their ruminative, compulsive life-style and seek an array of additional surgical procedures, all rationalized as necessary in their quest "to correct an error of nature." Tranquility, it seems will always be just beyond the next advance in plastic surgery.

Summary

By a review of the literature on transsexualism and a comparison of mean MMPIs of patients seeking transsexual surgery with those of adequately adjusted homosexuals, the author offers the conclusion that these patients can be best understood in terms of the psychoanalytic concept of "character nuerosis." Other dynamics that make "transsexualism" so attractive to these unfortunate men are discussed.

Acknowledgement: The author wishes to express his appreciation to Ian Gregory, M.D., Chairman, Department of Psychiatry, and to John Kangas, Ph.D., Department of Psychiatry, The Ohio State University College of Medicine, for their kindness in interpreting the MMPI profiles and for their constructive criticism of this paper.

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14. Newmen LE: Transsexualism in adolescence, problems in evaluation and treatment. *Arch Gen Psychiatry* **23**:112-121, 1970.

Carcinoma of the Common Bile Duct

Report of an Unusual Two-Year Remission After Intraluminal 5-Fluorouracil

Byers W. Shaw, M.D., and Marvin H. Roszmann, M.D

THIS COMMUNICATION CONCERNS a case of a papillary adenocarcinoma of the distal common duct which was treated by direct instillation of diluted 5-fluorouracil (5-FU) solution into the common duct by means of a T-tube. The obstruction was relieved and no tumor could be seen on a cholangiogram one year later.

The success of local chemotherapy depends on two criteria; first, the susceptibility of the tumor cells to the antitumor agent, and second, a satisfactory method of achieving direct and prolonged contact of the agent with the tumor cells. Selection of 5-FU as the agent satisfied the first, and instillation of this agent through a T-tube into the relatively small closed space of a common duct lent itself well to the second.

In 1962, Klein[1] reported disappearance of skin cancers following the direct application of solutions and creams containing 5-FU. Numerous reports[2] have followed and recently the practice has become much more common. In 1960, Rousselot and associates initiated a study in which intraluminal administration of 5-FU was used as adjunctive therapy to improve results of resection for cancer of the colon. It was hoped that the drug would locally kill cancer cells shed into the bowel lumen, and also, by means of mesentric absorption, sterilize any cells squeezed into the adjoining vascular or lymphatic tree. In 1965 and 1968, he published results confirming the benefit of this method.[3,4] The therapeutic value of systemic 5-FU in other tumors with generalized spread including carcinoma of the breast is well documented. Its local selectivity of effect on tumor cells with sparing of normal tissue and its low toxicity[5] has made it a valuable therapeutic drug. A survey of the literature did not reveal any report of a similar case so treated.

Submitted June 22, 1971 (Addendum submitted December 21, 1971).

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Case Report

History—A 54-year-old white woman of Italian lineage was admitted to the hospital on October 26, 1968. She had complained of malaise, generalized aching, and jaundice of 12 days' duration. She had been nauseated but had not vomited. She had noted dark urine and clay colored stools. Obesity had been a definite problem for years but there was no documented weight loss. She had had one previous hospital admission four years before for excision of a nontoxic nodular goiter.

Her family history was pertinent for its neoplastic tendency. Her father was living after a colon resection for carcinoma of the sigmoid. Her

mother had died of cystosarcoma phylloides of the breast. A 50-year-old brother was living after having a combined abdominal-perineal resection for carcinoma of the colon eight years previously.

Physical Examination—Examination revealed a short, obese, white female who was deeply jaundiced. The abdominal wall was thickened with obesity. There was some tenderness to deep palpation in the right upper quadrant. No organs or masses could be identified. Excoriations secondary to pruritus were present.

Hospital Course—Clinical and laboratory examinations pertinent to the evaluation of a jaundiced patient were done. The gallbladder was nonfunctioning. X-ray studies revealed the gastrointestinal tract was normal. Liver profile studies indicated obstructive jaundice. On her fourth hospital day, abdominal exploration was performed. The gallbladder was dilated and thick walled. The colon and omentum were adherent to it. The common duct was markedly dilated to a diameter of 2.5 cm. It seemed to be filled with a "mushy" substance. The common duct was opened and blood clots were evacuated. Exploration of the common duct revealed a papillary tumor filling the distal 2 cm of the duct. Large fragments of tumor were curetted from the duct with stone scoops. A T-tube was inserted and sutured in place, followed by a cholangiogram using 50 percent Hypaque. There was no passage of dye into the duodenum. A cholecystoduodenostomy was then completed.

The pathology report was as follows:

Gross—The specimen consists of 8 gm of fragments of granular gray tissue.

Microscopic—Sections reveal a papillary malignant tumor composed of darkly staining cells supported by a scant amount of fibrous stroma. Occasional acini are formed.

Diagnosis—Papillary adenocarcinoma (Fig. 1).

Postoperatively, the patient did well and the jaundice gradually cleared. On her seventh postoperative day, intraluminal instillation of 5-fluorouracil through the T-tube was initiated. 500 mg of 5-FU was diluted to 30 ml with normal saline. 10 ml was given three times a day. The T-tube was clamped for 30 minutes after each instillation. This was given to a total dosage of 3.0 gm in six days. On her 13th postoperative day, another cholangiogram was done (Fig. 2). The common duct was now smaller and there was prompt passage of dye into the duodenum. The distal common duct was narrowed and described as spastic. No tumor was identified on the films. She was discharged on her 14th post-



Fig. 1. Microscopic section showing papillary malignant tumor of glandular origin.



Fig. 2. T-tube cholangiogram done on 13th postoperative day. Common duct is mildly dilated; dye passes promptly into duodenum. Mild spasm of distal end.

operative day with the T-tube in place. The jaundice had cleared completely.

At home, her appetite returned and she quickly regained the little weight she had lost in the hospital. Twice a day she would open the common duct tube for 4 or 5 minutes; it drained very little.

She was readmitted on December 10, 1968 and another course of 3.0 gm of 5-FU was administered as above. A cholangiogram at the end of this course showed a common duct of gradually decreasing size without evidence of tumor. Serum bilirubin level was normal. On January 14, April 14, and September 15, 1969, courses of 5-FU were administered in the office giving 250 mg diluted with 10 cc of saline daily for four days. On February 21 and June 16, 1969, she was readmitted to the hospital and 1500 mg were given over a period of three days. Cholangiograms done on both these occasions were normal. Results of liver function tests remained normal.

The last cholangiogram was done on October 28, 1969 and showed no evidence of recurrence of the tumor (Fig. 3). The rubber in the tube was degenerating and had become quite shortened from repeated applications of a clamp. Removal of the tube seemed mandatory. On November 7, 1969, approximately one year from the time of surgery, the T-tube was removed. It was interesting that the portion of the tube inside the abdominal wall and in the peritoneal cavity had retained its elasticity and was in relatively good condition. A few small pieces of calcareous material followed the tube out through the fistulous tract as it was removed. Drainage from this tract ceased in 24 hours.

In the ensuing years, she gained weight to over 200 pounds. She has had no recurrence of jaundice. She works actively in her job as secretary to a manufacturing executive. She was last seen in April 1971, approximately two years and five months following the initial surgery, and is entirely symptom free.



Fig. 3. T-tube cholangiogram on 10/20/69, almost one year later. Common duct is open; no tumor is seen.

Discussion

It would be hazardous, indeed, to draw any conclusions from the response of one case of papillary adenocarcinoma of the common duct to intraluminal instillation of 5-FU. However, the disappearance of the tumor as observed on serial cholangiograms in response to the drug was dramatic. All surgeons are aware of the technical difficulties of resection of a common duct tumor and the head of the pancreas in such an obese patient and of the high mortality thus engendered. The two-year remission of this usually fatal tumor would seem to justify further trials of treatment by this method. Possibly less drug and a shorter period of treatment will prove to be adequate. The long-term survival would also be dependent on the absence of local and liver metastases at the onset of the treatment. It may prove to be a simple method of palliation even in advanced cases.

Conclusion

A case of papillary carcinoma of the distal common duct was treated by the intraluminal administration of 5-fluorouracil through a T-tube. The jaundice cleared and a follow-up cholangiogram one year later revealed no evidence of tumor. The patient remained well and free of symptoms and icterus for over 2½ years.

Addendum: Three years and one month after the original operation, the patient returned with jaundice. Abdominal exploration revealed a large carcinoma of

the common bile duct with obstruction. Biopsy report indicted poorly differentiated adenocarcinoma.

Generic and Trade Name of Drug
Sodium diatrizoate — Hypaque Sodium 50% Injection (Winthrop Laboratories)

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

While a two-year-old boy was eating peanuts, he suddenly coughed, choked, and then developed an audible wheeze. He was immediately brought to the emergency room.

Auscultation of his chest revealed rhonchi throughout the left lung. A chest x-ray film (Fig. 1) was interpreted as normal.

What is your next step in his evaluation and treatment?

(See p. 260 of this issue for further information and discussion.)



Fig. 1. Initial roentgenogram (taken during inspiration) showed chest within normal limits.

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Submitted August 2, 1971.

Tuberculosis of the Parotid Gland

Case Report

Raza M. Khan, M.D., and Charles L. Cogbill, M.D.

TUBERCULOSIS OF THE PAROTID gland is rare and has been reported in the literature only sporadically. In most case reports we have seen, the diagnosis was made on the basis of microscopic tissue examination rather than on bacteriologic findings. Because of the rarity of this condition, we should like to report a recent case with the diagnosis established both by histologic tissue examination and by the finding of acid fast bacilli in the specimen.

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Case Report

A 35-year-old white, male laborer was admitted to the Dayton Veterans Administration Hospital in March 1970 complaining of a painless swelling beneath the right ear of about three weeks duration. For a long period of time he had had repeated bouts of sore throat but none immediately before the appearance of the mass. There was no past history of tuberculosis. He had been a heavy drinker of alcoholic beverages in the past but not recently. He was a patient on the psychiatric service at this hospital in 1964-1965 and was discharged with a diagnosis of anxiety reaction and sociopathic personality.

On physical examination, the temperature, pulse, and respiration rate were normal, and blood pressure was 120/90 mm Hg. The patient was a well-developed and well-nourished man in no distress. There was a 2 X 4 cm, firm, movable, nontender mass in the region of the right parotid gland. There was no facial weakness. There was no lymphadenopathy in the neck or elsewhere. The tonsils were enlarged and hyperemic, but no other lesions of the mouth, pharynx, or larynx were seen. The remainder of the physical examination was within normal limits.

The hemoglobin, hematocrit, white blood cell count and differential urinalysis, venereal disease research laboratories test for syphilis, blood sugar, blood urea nitrogen, and prothrombin time were normal. The electrocardiogram was normal. Sputum cytologic studies showed no abnormal cells. Repeated 24-hour sputum concentration smears and cultures for acid fast bacilli were negative. Complement fixation tests for histoplasmosis, blastomycosis, and coccidioidomycosis were negative. The skin test for histoplasmosis was negative. The tuberculin skin test was positive. The chest roentgenogram (Fig. 1) showed marked enlargement of hilar lymph nodes with no evidence of pulmonary infiltration. (X-ray film of the chest in this hospital in 1964 had been entirely normal.) Roentgenographic examination of the skull and paranasal sinuses was normal as was intravenous pyelography. A right parotid sialogram showed enlargement of the parotid gland.

Needle biopsy of the right parotid gland showed chronic sialadenitis. Open biopsy was performed. Microscopic examination was reported as follows (Fig. 2): "(The specimen consists of) portions of salivary gland showing granulomatous reaction with multinucleated foreign body type and Langhans' type of giant cells replacing the glandular tissue. Scattered ducts are seen which are hyperplastic. Fibrous septa traverse the tissue. Special stain shows presence of acid-fast bacilli. Diagnosis: Biopsy parotid gland, right: Tuberculous granulomatous inflammation."

The patient was placed on treatment with isoniazid, para-aminosalicylic acid, and streptomycin, and he was

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followed as an outpatient. He got along well on this regimen. At follow-up in April 1971, he felt well, the parotid swelling had completely disappeared, and chest x-ray film showed marked diminution of hilar adenopathy (Fig. 3).

Discussion

The exact incidence of tuberculosis of the parotid is hard to determine because in a majority of reported cases the diagnosis was made by histologic examination alone and not by the finding of acid-fast organisms. It appears likely that some cases reported as tuberculosis were in fact sarcoid or fungal infections.

In patients with parotid tuberculosis it is unusual to find evidence of tuberculosis elsewhere and in most patients there is no family or personal history of this disease.[1,2] Such was the case in our patient, except for roentgenographic evidence of mediastinal lymphadenopathy. Spread is believed to be lymphatic, ductal, or blood borne.[2]

Usually the disease first appears as a painless swelling of the parotid gland (nodular type). In this type, the disease may be present for years and the swelling may remain circumscribed. In a few cases, the disease may be acute with diffuse swelling. In this type (diffuse type), the gland may be fluctuant and it may be possible to express pus from the duct.[2]

In the usual case which presents as a small, freely movable, circumscribed, painless swelling, the clinical diagnosis is mixed tumor of the parotid.[2] The correct diagnosis is made only by biopsy or excision and identification of acid-fast bacilli by appropriate cultural or staining techniques. In our case, the chest x-ray film suggested systemic disease, possibly lymphoma, and

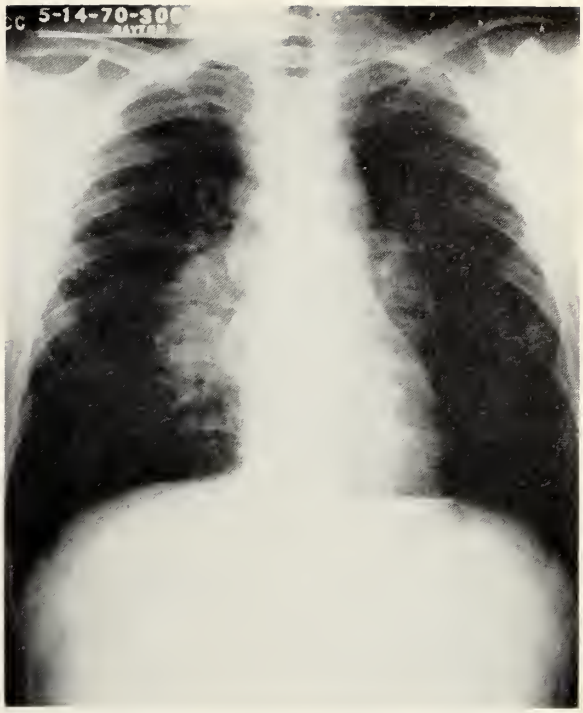


Fig. 1. Roentgenogram about one month following start of treatment shows bilateral hilar adenopathy, more marked on right. This film showed no change from admission film which was lost.

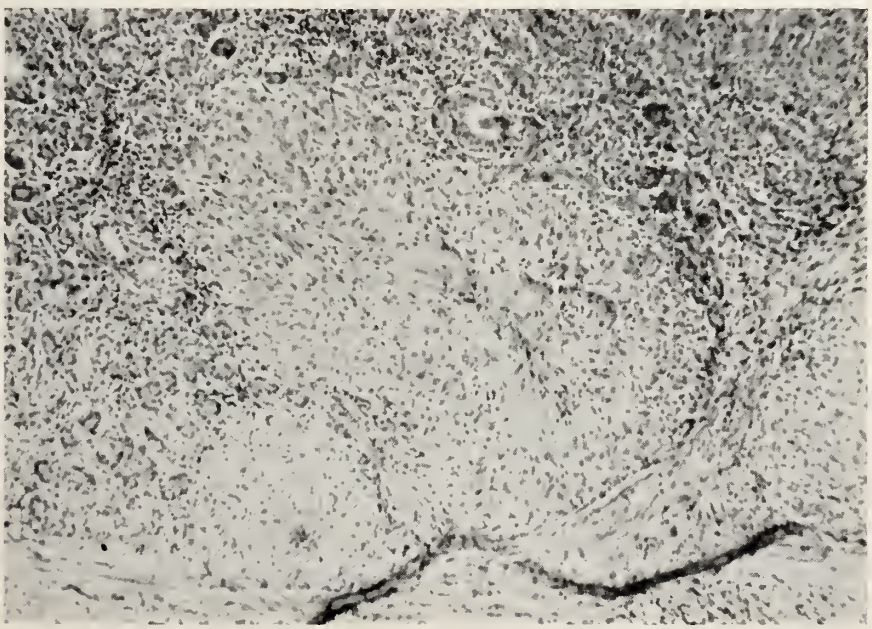


Fig. 2. Low power view of parotid showing scattered ducts and granulomatous tissue with giant cells.

biopsy of the localized swelling in the neck was performed in order to establish the diagnosis.

Microscopically, the picture is that of a granuloma. As such, differential must be made between tuberculosis, Boeck's sarcoid, histoplasmosis, or other fungal diseases.

Following excision of the local lesion good healing usually has occurred, even in the period before drug therapy for tuberculosis was available, and several writers have recommended this as the treatment of choice.[2-4] At the present time we agree with Work and McCabe[5] that excision should be followed by antituberculosis drug therapy. Our patient had only open biopsy rather than excision, but he has gotten along well (one year) on this management.

Summary

Tuberculosis of the parotid gland is a rare disease not usually associated with family or personal history of tuberculosis or with evidence of the disease elsewhere.

Diagnosis is made by biopsy or excision of the involved gland. The microscopic picture is that of a granuloma and the demonstration of acid-fast organisms by suitable staining or cultural technics establishes the diagnosis of tuberculosis. Treatment then should be carried out with antituberculosis drugs.



Fig. 3. Roentgenogram after one year of treatment shows marked decrease in hilar adenopathy.

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HYPERVENTILATION IN ACUTE CEREBROVASCULAR ACCIDENTS. — Lumbar cerebrospinal fluid and arterial blood acid-base state were assessed in 19 patients within 24 hours of an acute cerebrovascular accident. Those with hemorrhage into the cerebrospinal fluid showed a lower cerebrospinal fluid pH and higher cerebrospinal fluid lactate than those without hemorrhage but the P_{CO_2} was similar in the two groups, suggesting that this greater cerebrospinal fluid acidity was not responsible for a greater degree of hyperventilation. In those without hemorrhage an inverse relation was found between cerebrospinal fluid pH and arterial P_{CO_2}, suggesting that a nonchemical ventilatory drive — for example, due to central neurological damage — was responsible for the acid-base changes observed. — D. J. Lane, M.D., M. W. Rout, M.B., and D. H. Williamson, D.M., Oxford, *British Medical Journal*, 3:9-12, 1971.

Traumatic Thoracic Aortic Aneurysm

Report of a Case with Rupture into the Left Subpleural Space

Suk Soon Lee, M.D.; Emil Gutman, M.D.; Yung S. Park, M.D.; and Chonggi Mah, M.D.

PHYSICIANS should always keep in mind the possibility of a traumatic aneurysm of the thoracic aorta whenever patients present with a history of blunt chest injury. Otherwise the aneurysm can be easily overlooked because of associated external injuries as well as its own nonspecific clinical findings.[1]

Recently we had a patient who sustained a rupture of the thoracic aorta as the result of an automobile accident. This rupture was overlooked at another hospital. He developed a pseudoaneurysm and died suddenly following its rupture.

Case Report

The patient, a 25-year-old Negro man, was admitted to a hospital in Tennessee on August 24, 1970, following an automobile accident. Upon admission, the patient was found to have fractures of the left femur and left scapula and probable rupture of the left hemidiaphragm (Fig. 1).

The femoral fracture was reduced and fixed by an intramedullary nail. The left hemidiaphragm was repaired. At this time, considerable blood loss was noted via the drainage through thoracotomy tubes in the left pleural cavity. His hemoglobin dropped to a point requiring three units of blood. The roentgenogram, taken September 4, 1970, demonstrated changes in the chest but the significance of these changes was not recognized (Fig. 2).

The remainder of his hospital course was essentially uneventful, and the patient was discharged September 8, 1970.

On the morning of September 12, 1970, the patient suddenly developed hemoptysis and was admitted to the Veterans Administration Hospital, Dayton, Ohio, with complaints of pain in the left chest and shoulder. He stated that he had experienced shortness of breath on several oc-

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casions since the automobile accident. Ejection murmurs were audible in the second and third intercostal spaces along the left sternal border. The chest films on this date led the radiology service to suggest traumatic aneurysm of the thoracic aorta and it was recommended that aortography be performed (Fig. 3). However, on the same day the patient complained of sudden, severe pain in his abdomen and back, and he died on September 13, 1970, about three weeks after the automobile accident.

At autopsy, a sharp horizontal laceration of the descending thoracic aorta was found about 3 cm below the left subclavian artery, involving the entire thickness of the anteromedial half of the circumference. A pseudoaneurysm, measuring 6.5 X 6.5 X 2.5 cm, had ruptured into the visceral pleura in the hilar region above the pulmonary ligament. There was a massive subpleural hematoma of dark red, clotted blood, which compressed and displaced the left lower lobe medially. There was also left hemothorax with clotted blood (Figs. 4 and 5).

Discussion

Several reports have recorded the mechanisms leading to the formation of a thoracic aortic aneurysm following a blunt injury to the chest.[2-4] The most commonly reported site of the tear is the isthmus of the thoracic aorta, just beyond the takeoff of the left subclavian artery.[2-6]

Most patients die immediately; however, it has been reported that about 10 to 20 percent survive the initial injury.[4,7] Apparently, in these patients the adventitia and periadventitial tissues of the aorta are able to resist the aortic pressure. Bleeding from the aortic laceration can recur any time during the first few days after the injury, when the thrombus has a tendency to shrink and liquefy.[8] Although the time of greatest hazard is the first three weeks after the injury, the degree of fibroplasia in the vessel wall is still insufficient for complete safety for at least three months after the trauma.[8] During this critical period, our patient traveled by car and ambulated with the aid of crutches. These may have been factors contributing to the resultant rupture.

The paucity of symptoms is characteristic.[4,9,10] The physician's attention is usually focused on the external injuries, and, as in this case, the aortic laceration itself is overlooked.[11] The ejection murmur that has been reported[11] is probably due to the turbulent flow in the aneurysm.[12] Another clinical finding is that of a rapid, continuous, unexplained hemothorax.[3,5,13]

Radiologic findings of aortic lacerations have been well described.[14] and many of these are evident on serial roentgenograms.[6,9,11] An aneu-

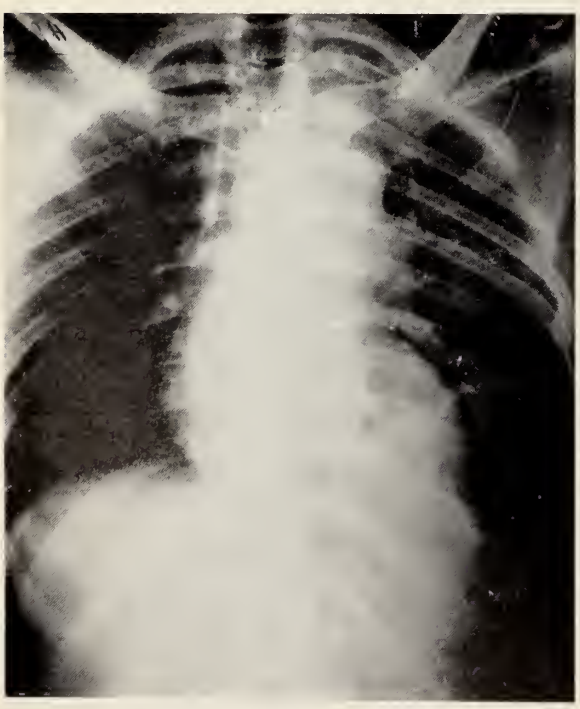


Fig. 1. Roentgenogram taken Aug. 24, 1970, immediately after the automobile accident, showing diffusely widened mediastinum, loss of aortic knob, fracture of left scapula and rupture of left hemidiaphragm. Trachea is deviated to the right.

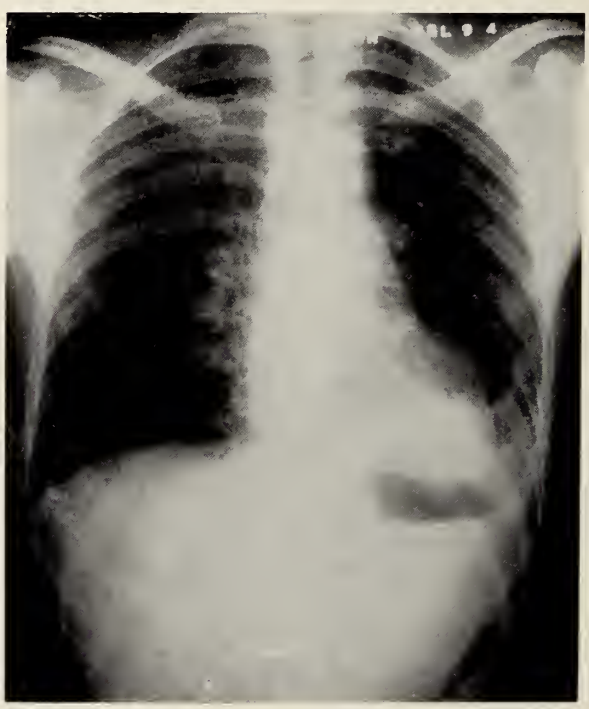


Fig. 2. In x-ray film of Sept. 4, 1970, early aneurysmal dilatation of the descending thoracic aorta and depression of left main stem bronchus are present.

rysm may develop within a few days or up to three or four weeks after the injury.[15] Therefore, even when the initial roentgenogram is negative, follow-up films are indicated whenever there is suspicion of aortic rupture.[1] A tortuous aorta in a young patient must always be considered an aneurysm until proven otherwise.[10]

Aortography should be performed because it shows the extent and the exact location of the tear of the aorta.[9,16] On the other hand, exploratory thoracotomy alone cannot adequately depict the lesion or the possible multiple tears that are present occasionally.[9,17]

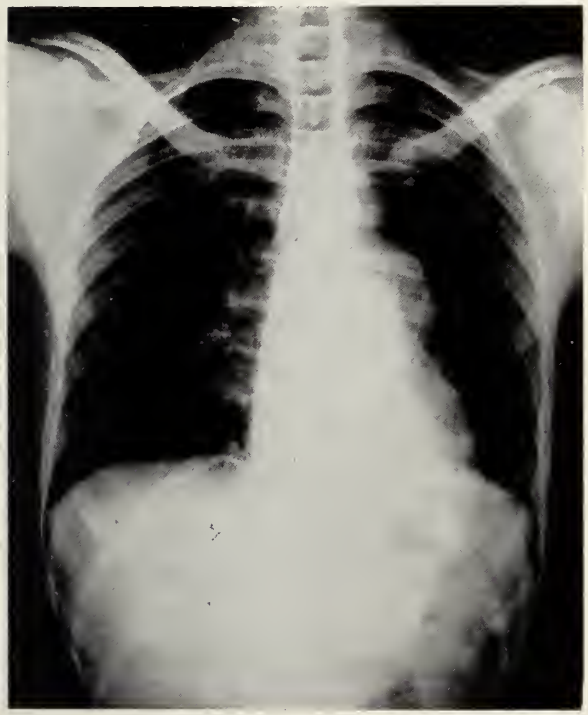


FIG. 3. X-ray film of Sept. 12, 1970. Aneurysmal dilatation of the descending thoracic aorta has increased in size.



FIG. 4. Postmortem radiograph reveals laceration of aorta and massive subpleural hematoma which is localized in left lower lobe.

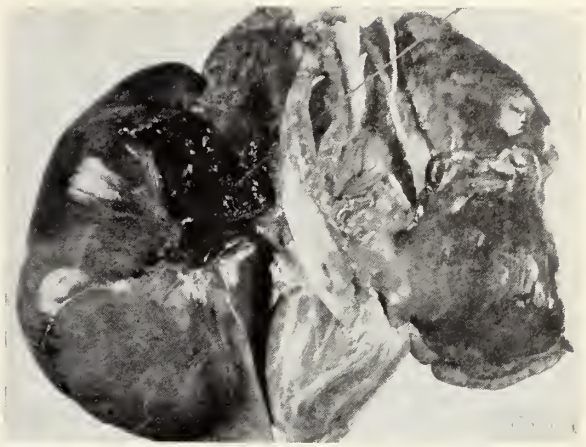


FIG. 5. Autopsy specimen reveals laceration of the thoracic aorta and ruptured visceral pleura with massive subpleural hematoma.

Jay[18] reported rupture of traumatic aneurysm of the thoracic aorta into the left main stem bronchus. This patient also had a sudden onset of hemoptysis. Another unusual case has been reported of a patient who, eight years after an automobile accident, had spontaneous rupture of a large traumatic aneurysm into the esophagus.[19]

Bernoulli's principle (with expansion of the aneurysmal sac, velocity through the aneurysm decreases and the lateral wall pressure increases on the aneurysmal wall) and La Place's equation (tension on the aneurysmal wall is directly proportional to the radius of the aneurysm) indicate that an aneurysm will increase in size.[12] Immediate surgery is suggested as soon as the diagnosis is made.[20]

Summary

A case has been presented of a patient with rupture of a traumatic aneurysm of the thoracic aorta. The physician's suspicion of this development after trauma is the most important factor in establishing the correct diagnosis. Often, follow-up is very difficult, so emergency angiography and prompt surgical intervention must be carefully considered, if indicated.

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Discussion of E.N.T. Case of the Month

(continued from p. 253)

The history is classic for a bronchial foreign body. The chest roentgenogram was read as normal because the foreign body was nonopaque and the film was taken during inspiration.

Bronchial foreign bodies may only partially obstruct the bronchus. In this situation air may pass easily around the foreign body because of the bronchial dilitation that occurs during inspiration, thus the involved lung will appear normal if an x-ray film is taken during inspiration. However, during expiration the bronchial lumen decreases in diameter, the passage becomes closed, and the air becomes trapped within the involved lung. The radiographic picture then will show hyperinflation of the involved lung.

Of course if the foreign body completely obstructs the bronchus, atelectasis will develop distal to the foreign body with collapse of the involved bronchial segments.

It is essential in patients with suspected bronchial foreign bodies to obtain both inspiratory and expiratory x-ray film studies of the chest.

In this case, the expiratory film showed hyperinflation of the left lung with a mediastinal shift to the right and depression of the left diaphram (Fig. 2), illustrating this obstructive phenomena.

The treatment for bronchial foreign bodies is immediate bronchoscopy with removal of the foreign body.



Fig. 2. Roentgenogram of chest (taken during expiration) revealed hyperinflation of left lung with mediastinal shift to right, indicating partial obstruction of left lung with resultant expiratory obstructive emphysema.

Maternal Mortality Report for Ohio – 1969

By the OSMA Committee on Maternal Health

WITH A SENSE OF SATISFACTION in accomplishment, the Committee on Maternal Health publishes the FIFTEENTH Annual Report for the year 1969. The document is prepared and presented in compliance with a House of Delegates directive creating the Committee and subsequent follow-up action by the OSMA Council, January 16, 1954.[1]

Five sections, as usual, comprise this report. The first part relates to activities engaging your Committee since its last report to the Council on July 11, 1971.[2] In the second section several committee projects are described representing developments to fulfill its assigned functions, while the third portion contains a detailed statistical summary gleaned from the Ohio Study during the year 1969. As it covers all 88 counties in Ohio, the data includes not only hospitalized patients but also those who "died at home." Part four summarizes and discusses the data and also Ohio Vital Statistics; finally, *recommendations* are submitted by your Committee based upon its experiences with "Maternal Health in Ohio."

Activities

Twenty members comprise the Committee, representing the 11 Councilor Districts in Ohio. The member who departed for assignment in another state is to be replaced by an appointment to be made by the incoming President next May 1972. Conforming to previous policies,[1] every attempt is made to have committee members represent the family physician, as well as specialists in obstetrics and gynecology, anesthesiology, pathology, and internal medicine, respectively.

As this column goes to press, the 55th meeting of the Committee is planned for January 15-16, 1972; a report of its deliberations will be carried in a future article. This will also include data on the total cases reviewed during the past year, as the Committee studies and reviews cases using "Guiding Principles"[3] as a baseline for "Ideal Care."

Two members of the Committee, Brandeberry and Ruppersberg, serve on the Advisory Council to the Revisions Committee for Rules Governing Licensure of Maternity Hospitals of the Ohio Department of Health. There were three meetings during 1971.

One member (Ramsayer) continues to serve on the Public Health Council; two members (Ramsayer and Ruppersberg) serve faithfully on the State Medical Board. The latter is of considerable importance, since the Board examines and issues licenses also to *Registered Nurse Midwives.*

Communications and queries relative to the Ohio Study have been received from (1) the Chairman, Committee to Study Quality of Surgical Care, American College of Surgeons; (2) Maternal Health Committee, National Health and Medical Research Council, Commonwealth of Australia.

Personally, the Chairman had the privilege of visiting Queen Mary Hospital, and Tsan Yuk (maternity) Hospital, both in Hong Kong, during July 1971. Personnel of each institution were highly interested in the operation and results of the Ohio Study.

Projects

The system of data processing 1462 IBM cards to collect statistical data continues. However, with the removal of Service Bureau Corporation from Columbus to Cincinnati, valiant efforts to discover a local agency equipped to continue our project were rewarded! Through an intercoordinated movement, the Data Processing Division of Ohio Medical Indemnity Corporation will assist in the maintenance of this important research project; eventually, the material will be gradually transposed for computer processing.

Presently, members of the Committee plan for an exhibit to be displayed at the May 1972 OSMA Annual Meeting in Cincinnati. The title and contents will be announced after the January 15-16, 1972 meeting in Granville.

At the OSMA Annual meeting, 9:30 to 10:30 a.m., Wednesday, May 10, 1972 (Cincinnati), the Committee will provide a Curbstone Consultation Seminar, entitled "OB Emergencies."

Adding to over 100 articles published in the "Maternal Health in Ohio" column of the

OSMJ, the Committee continues the column on a quarterly basis. Recently a slight deviation from the usual content was attempted. "Maternal Deaths: Unusual Cases"[4] appeared as the year 1971 ended. This trend will be repeated from time to time.

Material from this column also appears (by permission) in a relatively new annual publication, *Searle Survey of Obstetrics and Gynecology.*

The Committee continues close liaison with well-established *county* maternal mortality studies. Six of these operate annually, in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron. Principally, they are supported by their respective obstetric-gynecologic societies, in cooperation with the county medical societies.

In the following columns, the Committee presents statistics from The Ohio Study for the year 1969. Comparison with various past and future reports is facilitated by the uniformity and use of terminology and nomenclature prescribed in *The International Classification:*

Ohio Maternal Mortality Study
Statistics for 1969

Total Live Births in Ohio, 1969		**189,099**
(Total Cases in files, 15 years, 1955-1969		1465)
Total cases studied (1969)		58
Cases not studied due to lack of information	6	
Undetermined	0	
Maternal Deaths (Classified)		**44**
Non-white (including one Oriental)	15	
White	29	
Age:		
Teens	5	
20's	25	
30's	12	
40's	2	
Parity:		
Primigravidae	7	
Multiparae	33	
Unknown	4	
Place of Death:		
Hospital	41	
Home	3	
Other	0	
Type of Delivery:		
Not recorded	0	
Operative	24	
Nonoperative (spontaneous)	10	
Not delivered	10	
Route of Delivery:		
Not recorded	0	
Vaginal	24	
Cesarean	7	
(antemortem)	7	
(postmortem)	0	
Laparotomy (ectopic preg.)	3	
Not delivered	10	
Case Classification: (when death occurred)		
Not known	0	
Group I (fr. concept. to 20th wk.)	4	
Group II (fr. 20th wk. to 28th wk)	2	
Group III (fr. 28th wk. through term)	4	
Group IV (postabortal, postpartum)	34	
Autopsies (includes 10 coroners' cases)	36	
Prenatal care (apparent from data sheets):		
None	6	
Unknown or not reported	2	
Adequate	20	
Inadequate	9	
Excluded (ectopic preg. and abortion)	7	
Classification of preventability:		
Nonpreventable	17	
Preventable (avoidable factor)	27	
Patient responsibility (P_1)	9	
Personnel responsibility (P_2)	16	
Both P_1 and P_2	2	
P_3 (Misc.)	0	
Classification of Primary Causes of Death:		
Hemorrhage		**12**
Abortion, without sepsis	0	
Abruptio	1	
Afibrinogenemia	1	
Abruptio	1	
Am. fl. embolus	0	
Dead fetus	0	
Ruptured uterus	0	
Atony, uterine, postpartum	3	
Ectopic pregnancy (without sepsis)	3	
Laceration, extrauterine	1	
Placenta praevis	0	
Retained placenta	0	
Ruptured uterus (no afibrin.)	2	
Other	1	
High Risk Related: 0 Non-Related: 3		
Infection		**9**
Abortion, alleged "criminal"	0	
Abortion, septic, spontaneous	3	
Up. resp. inf.	0	
Peritonitis	4	
Septicemia (puerperal sepsis)	0	
Septicemia (other)	1	
Pyelitis-pyelonephritis	1	
High Risk Related: 0 Non-Related: 5		
Toxemia		**4**
Acute yellow atrophy	0	
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	0	
Eclampsia	3	
Renal disease	1	
Puerperal toxemia, not specified	0	
High Risk Related: 0 Non-Related: 1		
Other		**19**
Amniotic fl. emb. (no hemorrhage)	4	
Anesthesia	1	
(general)	1	
(regional)	0	
Cardiac arrest	1	
Cardiac disease	3	
Cerebrovascular hemorrhage (no tox.)	2	
Drug poisoning	1	
Liver disease	0	
Lower nephron-nephrosis	0	
Pulmonary edema	1	
Pulmonary embolus	6	
Suicide	0	
Ulcerative colitis	0	
High Risk Related: 5 Non-Related: 7		

In Ohio, there were 189,099 live births reported during 1969. From this maternal mortality study, the Committee classified 44 maternal deaths for the year. The maternal mortality rate was 0.23 per 1,000 live births, or 2.33 per 10,000 live births for 1969.

Furthermore, it is reported[5] that, in addition to the 189,099 *live births,* there were also 2,426 *stillbirths* (fetal deaths), during 1969. Also reported[5] is the fact that among 189,099 *live* births,

there were 17,259 *illegitimate births;* 49 percent of these occurred among mothers *under* the age of *20 years.*

The number of live births recorded in 1969 represents a rate of 17.5 per 1,000 population, or a rise of 1.9 percent over 1968. Thus, the number of live births each year has *increased* in Ohio since 1967.

Discussion

Although only 44 maternal deaths are recorded among 58 cases studied in 1969, there are still six cases to be reviewed; hence the reader will see that this maternal mortality study has a "plastic" or slightly "malleable" potential for case collection. Only recently, several patients who died in 1966, 1967, or 1968 were discovered, and their cases added to the files, *after* an annual report was published!

Of the 44 maternal deaths for 1969, (again) five were "teenagers," while the majority was in the 20-year age bracket. Nearly all (but *three*) deaths occurred in a hospital. (This shows the importance of county-wide case collection!)

Ten patients died undelivered, while the great majority of deliveries were operative (not spontaneous). All of the seven cesarean sections were *antemortem;* three laparotomies were performed for ectopic pregnancy. Thirty-six of the 44 patients were submitted to autopsy; the coroner performed approximately one third of these.

Either *no* prenatal care, or *inadequate* prenatal care was reported for 15 of the patients while 20 patients received *adequate* care; the remaining nine were excluded or not reported.

After studying all available information, the Committee voted 17 deaths nonpreventable. Of the remaining 27 preventable deaths, 16 were assessed personnel responsibility.

Again, *hemorrhage* leads the parade of *primary* causes of death, with 11 cases; next in succession are infection (nine cases) and toxemia (four cases) respectively. Pulmonary embolism leads "other causes" with *six* deaths; next is "amniotic fluid pulmonary embolism" (proven by microscopic examination) with *four* cases (Fig. 1).

Among the 44 maternal deaths, 27 were classified as "High-Risk-OB"[3] patients, *before* pregnancy; about one fourth of these (five) had factors related to the primary cause of death! All of these came under "other causes" classification.

Recommendations

1. Of course, the Committee recommends continuation of the Ohio Maternal Mortality Study, with its research and educational facets. Only by a careful *annual* survey of statistics can the variation in trends related to maternal mortality and morbidity be ascertained.

2. Education and information projects should continue their focus into trends of *prevailing* maternity problems, in the future.

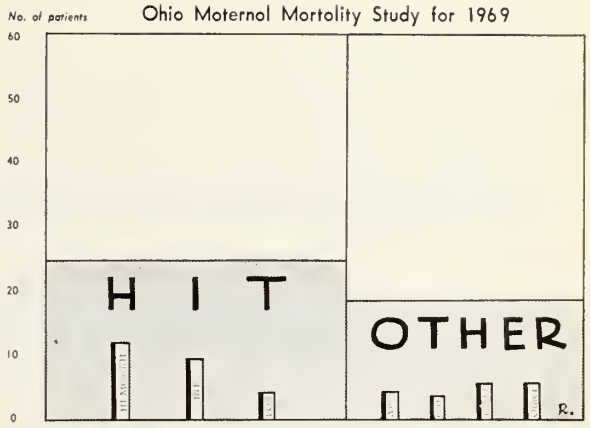


Fig. 1. Classification of primary causes of death, 44 maternal deaths for 1969.

3. The Committee should extend its activities to study major causes of *maternal morbidity* in Ohio.

4. Based upon plans to devise programs and implementation of computer-oriented data processing methods in the future, for Ohio Maternal Mortality Statistics, it is recommended that the Council consider a slight increase in the Committee's budget for 1973.

With appreciation, the Chairman acknowledges the devotion and support of Committee members, who completed their duties effectively during the past year. For the Committee, the Chairman gratefully acknowledges the assistance extended by the Council, attending physicians, representatives of the many county medical societies, the Ohio Department of Health, Ohio Coroners Association, and numerous other agencies and individuals. Without their continued cooperation and support, this Maternal Mortality Study could not have been completed.

Respectfully submitted,

Anthony Ruppersberg, Jr., M.D.

Chairman, Committee on Maternal Health

Approved by The Council of the Ohio State Medical Association, February 13, 1972.

References

1. Maternal mortality study, statewide basis. *Ohio State Med J* 51:886-888,1955.
2. Committee on Maternal Health: Maternal mortality report for Ohio—1968. *Ohio State Med J* 67:824-826, 1971.
3. Guiding principles for obstetric care. *Ohio State Med J* 63:1612-1614, 1967.
4. Committee on Maternal Health: Maternal deaths: unusual cases. *Ohio State Med J* 67:1100-1101, 1971.
5. Ohio Department of Health, Bureau of Vital Statistics: Special communication.

Professional Activities



OSMA Group Term Life Insurance Returns 47 Percent Dividend

Over 2,000 doctors and employees participating in the Ohio State Medical Association Group Term Life Insurance plan received a 47 percent dividend for the period September 1, 1970 through August 31, 1971. Presently, approximately $28,000,000 in insurance is in force as reported by Turner & Shepard, Inc., administrator of the plan.

Dividends have been paid on this plan since its inception, but this cash dividend of 47 percent is the highest which the plan has earned in any policy year. This year's dividend was distributed in the form of a premium reduction on the March 1, 1972 billing.

Group term insurance in the amount of $10,000 was first offered in 1958. The plan has been continually improved since that time, and now offers a maximum of $50,000 (in $10,000 units) for each physician member. Last year, the plan was amended to make coverage available to professional corporations; many of these corporations now use the OSMA group term coverage as an important employee benefit, as premiums are tax-deductible to the corporation, and are not considered as income to the physicians and other corporation employees.

The advantages of the plan include accidental death and dismemberment, which means double the face amount is paid at the time of accidental death or one-half payment for the loss of a hand, foot, or eye. Also, if a participant is disabled and unable to work, the plan stays in effect through a waiver of premium provision.

The term insurance can also be converted to an individual ordinary life insurance policy if you terminate your membership in the OSMA for any reason. The death benefits are payable as a single sum or in options which you or your beneficiary may select.

All OSMA members in good health are eligible to participate in the plan. New members are eligible for coverage without evidence of insurability, if they apply within 90 days. Employees of doctor members of the OSMA are also eligible.

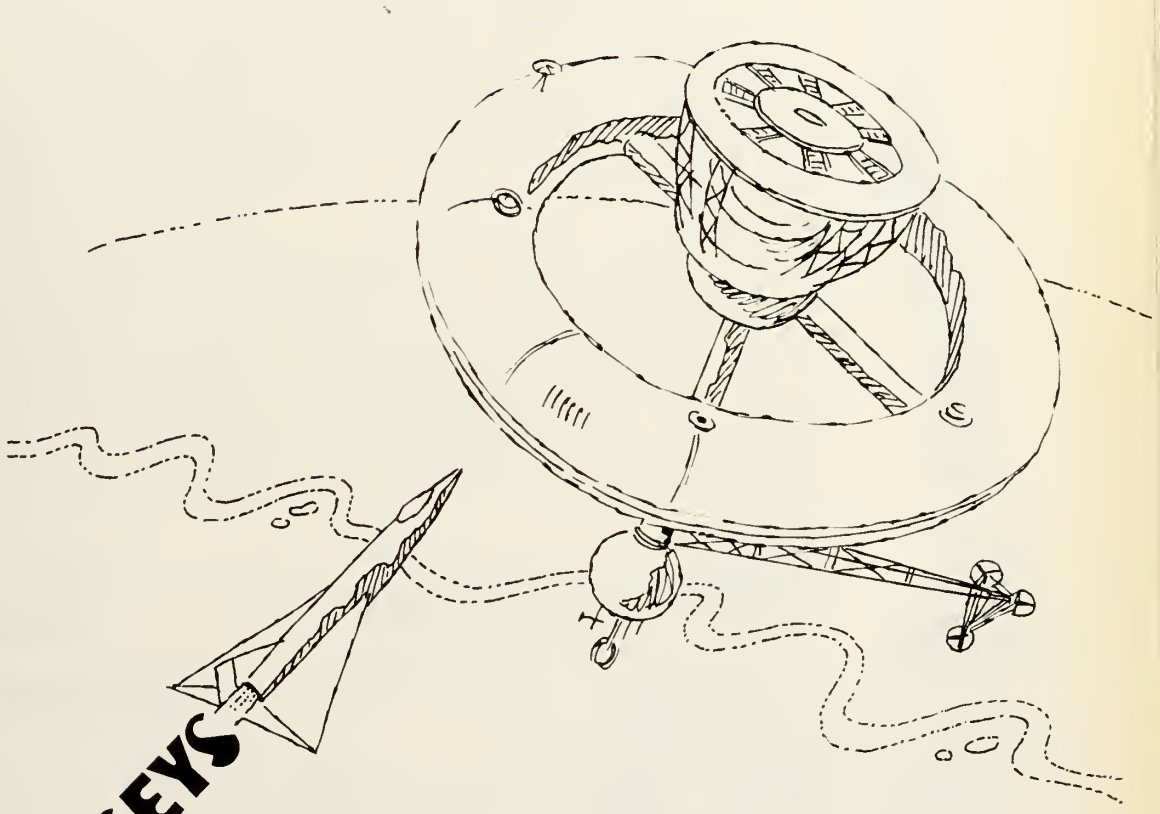
Additional information about the group term life insurance plan can be obtained by contacting Turner & Shepard, Inc., 17 South High Street, Columbus, Ohio 43215.

Toledo Area Cancer Conference Announced

An ad hoc committee of interested physicians in Toledo in cooperation with the Northwestern Ohio Regional Medical Program, the American Cancer Society, the Academy of Medicine of Toledo and Lucas County and the Medical College of Ohio at Toledo are planning a conference entitled "New Developments in Clinical Cancer" to be held in Toledo June 1, 2, and 3.

Request for additional information should be directed to: Charles D. Cobau, M.D., Director of Medicine, The Toledo Hospital, 2142 North Cove Blvd., Toledo, Ohio 43606.

1972
OSMA
ANNUAL MEETING



MEDICAL ODYSSEYS
1995

WEEK OF MAY 7th 1972

CINCINNATI
EXPOSITION CENTER

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A LOOK INTO THE FUTURE

1972 OSMA ANNUAL MEETING

MAY 8-11, 1972 CINCINNATI, OHIO

Stouffer's Cincinnati Inn — Headquarters Hotel
Cincinnati Exposition Center — Meeting Rooms and Exhibits



An array of subjects will be covered during the 1972 Annual Meeting. Regardless of your specialty or specific interest, OSMA has gone all out to provide something which will be useful to you in the ensuing year. Make arrangements now to spend the week of May 7 in Cincinnati, Ohio. Visit the Scientific, Health-Education and Technical Exhibits in the beautiful Cincinnati Exposition Center. All scientific meetings and House of Delegates meetings will be held in the Exposition Center. All hotel facilities are within minutes from the Exposition Center.

The Ohio State Medical Association and the Medi-Art Club of the Academy of Medicine of Cincinnati will be sponsoring a PHYSICIAN'S ART SHOW. All Members of the Ohio State Medical Association and their wives and Members of the Medi-Art Club are invited to compete in this show. All interested parties please get in touch with Harry H. Fox, M.D., Chairman, Art Show Committee, 19 West 8th, 368 Doctors Building, Cincinnati, Ohio 45202 for particulars.

OMPAC LUNCHEON

Wednesday, May 10, 1972

11:30 A.M.

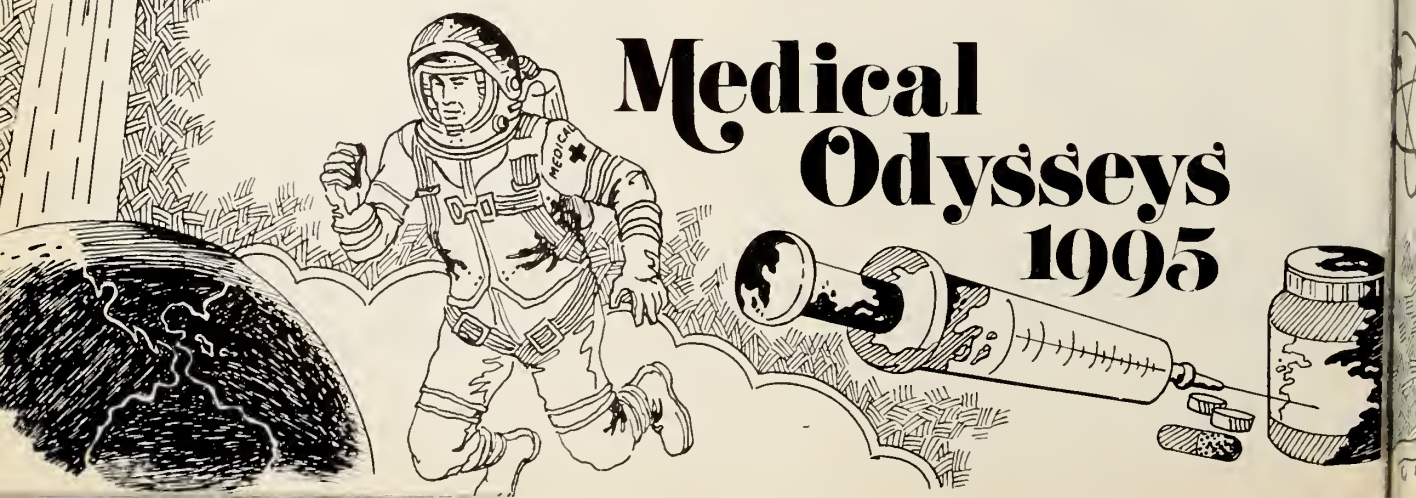
Speaker: Mr. Robert D. Novak
Washington Columnist and Author

Subject: "Politics — 1972"

"Riverboat Odysseys: 1895"

Wednesday evening, May 10, 1972
7:00 P.M.

Johnston Party Boats
Foot of Broadway



SETS THE PACE FOR THE...

PRE-REGISTRATION

All persons pre-registered may pick up their badge, program and tickets for OMPAC luncheon and "Riverboat Odysseys: 1895" party at the pre-registration desk in your name. Clip the coupon, fill out the information requested along with your **check in the proper amount** so that we may reserve tickets for you. This one step now will save you time later.

Annual Meeting Pre-Registration and Ticket Form

SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to: Ohio State Medical Association

Mail this form to: Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215

Wednesday, May 10, 11:30 A.M.

"OMPAC Luncheon"

Cincinnati Exposition Center

$5.00 per person

Number_____

Wednesday, May 10, 7:00 P.M.

"Riverboat Odysseys: 1895"

Johnston Party Boats
Foot of Broadway

$12.00 per person
(Special Price to Exhibitors of $9.00 per person)

Number_____

Name_____
(Please Print)

Address_____
(Number and Street) (City) (State)

I am:

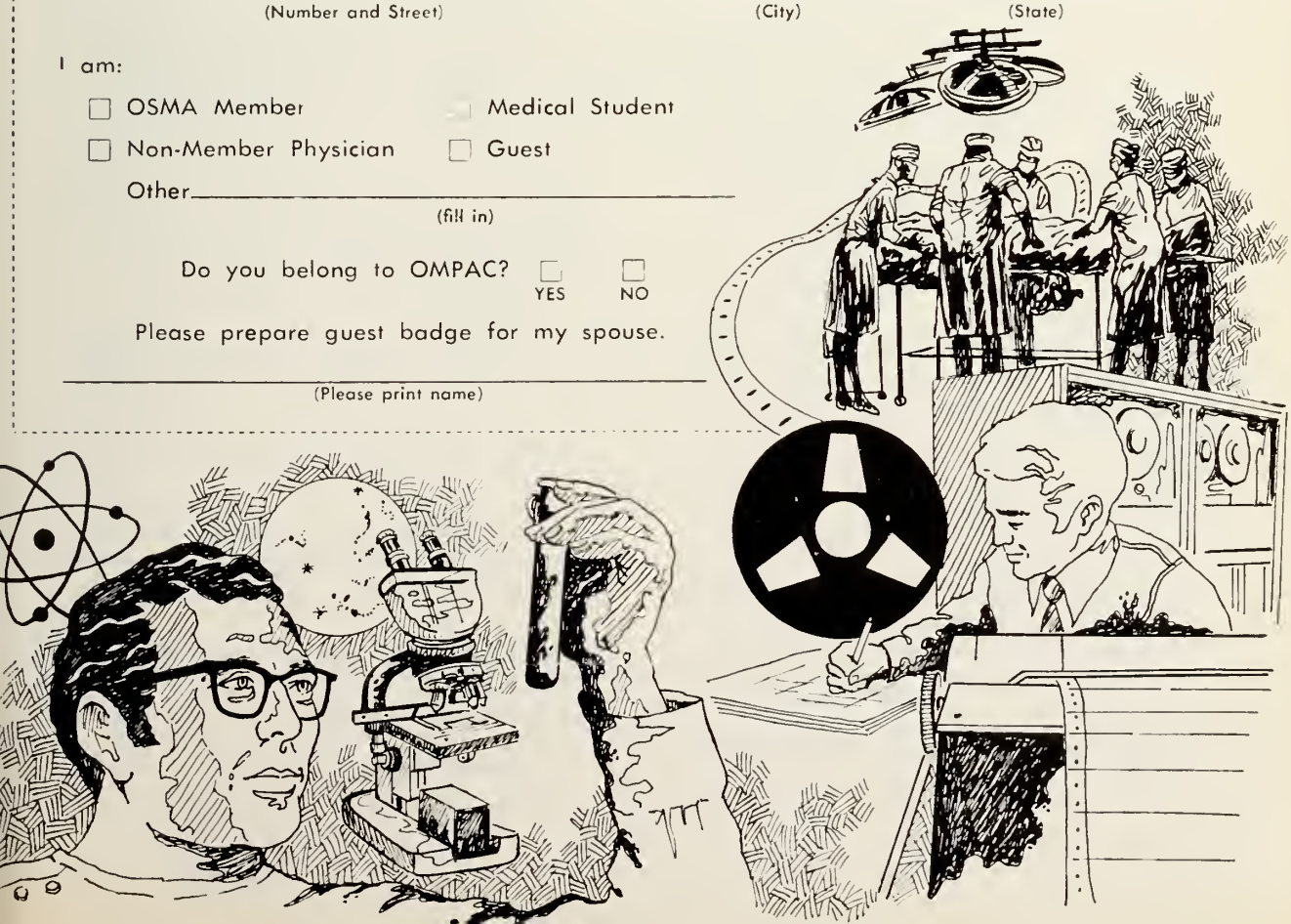
- ☐ OSMA Member
- ☐ Medical Student
- ☐ Non-Member Physician
- ☐ Guest

Other_____
(fill in)

Do you belong to OMPAC? ☐ YES ☐ NO

Please prepare guest badge for my spouse.

_____
(Please print name)



A to Z Approach on the Etiology, Prevention and Treatment of Coronary Artery Disease

Cincinnati Physicians to Present OSMA Scientific Program

Tuesday, May 9, Cincinnati Exposition Center

A scientific program designed to answer the many questions from office diagnosis to management of difficult problems in Coronary Artery Disease, taking into consideration the systemic system of the "wholeman." This program will be of interest to **ALL physicians** in their everyday practice, and we are certain you will want to make it a MUST for your Annual Meeting Schedule.

PROGRAM
Tuesday, May 9, 1972
Morning Session

Presiding: John Albers, M.D., Cincinnati

9:00- 9:35 a.m. **Etiology and Prevention of Coronary Artery Disease** — Charles Glueck, M.D., Cincinnati

9:40-10:15 a.m. **Family Practitioner Looks at Coronary Artery Disease —**
- **Office Diagnosis**
- **Office Therapy**
- **When to Hospitalize — In-Patient Therapy**
- **When to Refer and Whom to Refer**

Speaker: Milton Gwinner, M.D., Cincinnati

10:15-10:45 a.m. Break for Tour of Exhibits

10:45-11:20 a.m. **Cardiologist Looks at Coronary Artery Disease —**
- **Pre- and Post-Infarction States**
- **Continued Uncontrolled Angina**
- **Persistent Arrhythmias**
- **When to Refer and Whom to Refer**

Speaker: Charles W. Abbott-Smith, M.D., Cincinnati

11:25-12:00 p.m. **Panel Discussion on Medical Treatment of Coronary Artery Disease —**

Moderator: John Albers, M.D., Cincinnati

Participants: Doctors Charles Glueck, Milton Gwinner, Charles W. Abbott-Smith and Georges Daoud

Tuesday, May 9, 1972
Afternoon Session

2:00-2:35 p.m. **Radiographic Diagnosis in Coronary Artery Disease —**
- **Whom to Catheterize**
- **When to Catheterize**
- **Diagnosis in Acute Infarction Period**
- **Complications of Catheterization**

Speaker: Georges Daoud, M.D., Cincinnati

2:40-3:15 p.m. **Surgical Management of Coronary Artery Disease —**
- **Revascularization Procedures**
- **Aneurysms of Left Ventricle**
- **Pacemakers**
- **Counter Pulsation Procedures Using Intra-Aortic Balloon**

Speaker: James Helmsworth, M.D., Cincinnati

3:20-4:00 p.m. **Panel Discussion on Management of Difficult Problems in Coronary Artery Disease —**

Moderator: John Albers, M.D., Cincinnati

Participants: Doctors Georges Daoud, John Flege, James Helmsworth, John Holmes and Ernest Meese.

Interested in Safeguarding the Health of the Athlete? Attend the OSMA Section on Sports Medicine

Wednesday, May 10, Cincinnati Exposition Center

The program is being sponsored by the OSMA Section on Sports Medicine and is being scientifically oriented to and for physicians. This program is designed for those interested in the physiology and/or pathology of injuries or more importantly the health of an athlete.

PROGRAM

Wednesday, May 10, 1972

9:00 a.m. Introduction — Sol M. Maggied, M.D., West Jefferson, Chairman, Section on Sports Medicine and Joint Advisory Committee on Sports Medicine of Ohio State Medical Association and the Ohio High School Athletic Association

Remarks: Harold A. Meyer, Ph.D., Commissioner of the Ohio High School Athletic Association

9:10 a.m. **"Physiology of Heat Dissipation"**

Speaker: Robert J. Murphy, M.D., Columbus, Team Physician, Ohio State University

9:30 a.m. **"Pathology of Effects of Heat on Athletes"**

Speaker: Frank P. Cleveland, M.D., Cincinnati

9:50 a.m. **"Effect of Rhythmic and Static Exercise on Athletes"**

Speaker: Roland L. Wiley, Ph.D., Associate Professor, Department of Zoology, Miami University, Oxford

10:10 a.m. Break for Tour of Exhibits

10:30 a.m. **"Functional Anatomy of the Knee as Related to the Pathomechanics of Injuries to this Joint"**

Speaker: Theodore A. Fox, M.D., Chicago, Illinois, American Board of Orthopaedic Surgery

11:10 a.m. **"Nutrition and Athletics"**

Speaker: Richard C. Bozian, M.D., Cincinnati General Hospital

11:30 a.m. Panel Discussion (involving all participants)

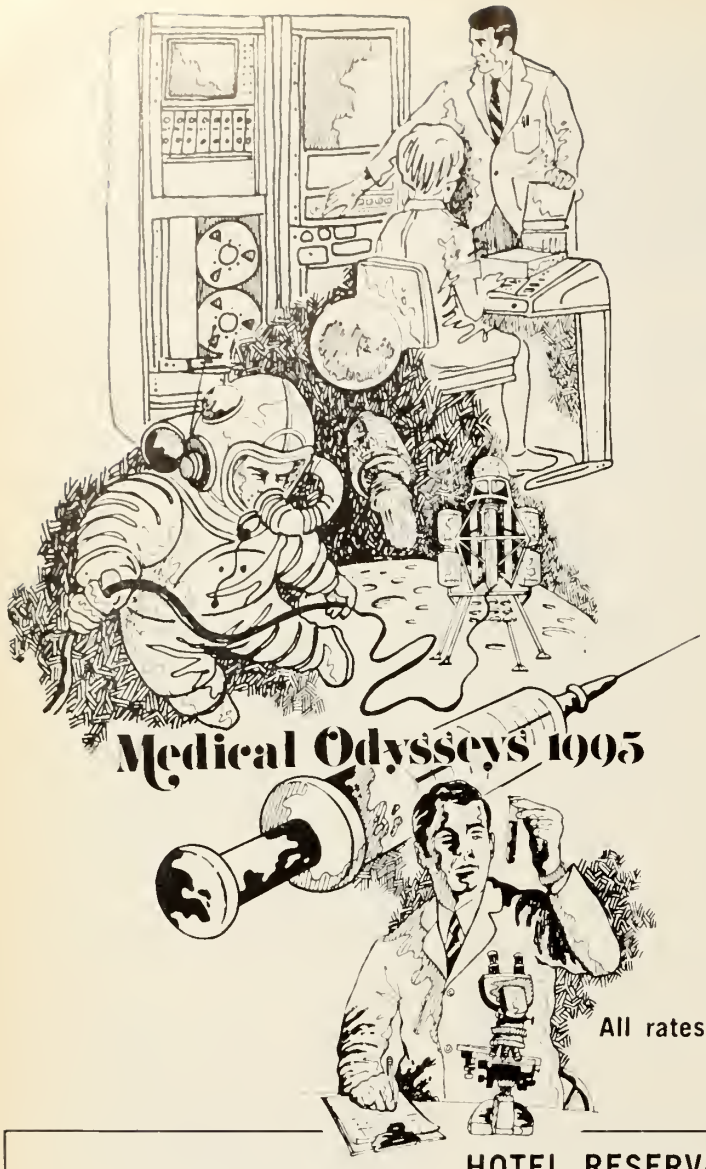
12:00 noon Adjournment

Provisions in OSMA Bylaws Pertaining to Nomination of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Cincinnati, May 8-11.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 9.

The Part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect."



Make Your Hotel Reservations For The 1972 OSMA Annual Meeting

MAY 8-11
CINCINNATI, OHIO

STOUFFER'S CINCINNATI INN
150 West Fifth Street
Cincinnati, Ohio 45202
(OSMA Headquarters)

Singles	$17.50 - $23.50
Doubles	$22.50 - $27.50
Twins	$24.50 - $36.50

SHERATON-GIBSON HOTEL
421 Walnut St.
Cincinnati, Ohio 45201

Singles	$12.50 - $21.00
Doubles or Twins	$18.00 - $27.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.

Mail Today

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Cincinnati, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 8-11 (or for period indicated).

_____ Single Room _____ Twin Room

_____ Double Room Other Accommodations _____

Price Range _____ Guaranteed _____

Arrival: May _____ at _____ A.M. _____ P.M.

Departure: May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

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Address _____

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Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



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Worry, frustration, job pressure—all set up excessive vagal currents in patients with peptic ulcer.

Pro-Banthine "insulates" the stomach, the duodenum and the lower intestinal tract—the sites where these destructive currents take their toll.

This "insulation" helps block excessive enteric activity and acidity, thus helping to provide the proper environment for the healing of peptic ulcers.

It's nice to know that Pro-Banthine provides this protection at a dosage that causes little or no discomfort and that, unlike ataractic agents, Pro-Banthine does not cloud the patient's awareness or thought processes.

By moderating excessive vagal currents Pro-Banthine relieves spasm, acid burn and pain. By reducing gastric motility Pro-Banthine also prolongs the activity of antacids.

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Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

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Indications: Relief of anxiety and tension; adjunctively in various disease states in which anxiety and tension are manifested; and to promote sleep in anxious, tense patients.
Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to meprobamate or related compounds such as carisoprodol, mebutamate, tybamate, carbromal.
Warnings: *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, than gradually withdraw. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between meprobamate, alcohol, and other CNS depressants or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. Animal data at five times the maximum recommended human dose show reduction in litter size due to resorption. Meprobamate appears in umbilical cord blood at or near maternal plasma levels, and in breast milk at levels 2-4 times that of maternal plasma. *Children Under Six:* Drug not recommended.
Precautions: To avoid oversedation, use lowest effective dose, particularly in elderly and/or debilitated patients. Consider possibility of suicide attempts; dispense least amount of drug feasible at any one time. To avoid excess accumulation, use caution in patients with compromised liver or kidney function. Meprobamate may precipitate seizures in epileptics.
Adverse Reactions: *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.
Usual Adult Dosage: 1200 to 1600 mg daily, in three or four divided doses; doses above 2400 mg daily not recommended.
Overdosage: Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

REV. 10/71

Before prescribing, consult package circular or latest PDR information.



WALLACE PHARMACEUTICALS
Cranbury, N.J. 08512

"Medicine's Socio-economic Forecast"

Physicians Project into the Future by Providing a Full-Day Program on Socio-economic Subjects Which Affect Medicine

This program is cosponsored by the Ohio State Medical Association, Ohio Society of Internal Medicine and the OSMA Section on Internal Medicine. This particular program could be entitled "Medical Odysseys: 1995" in keeping with the general theme of the 1972 Annual Meeting. There has been an increasing demand from the OSMA membership to have programming on not only scientific subjects but socio-economic subjects which affect the physician and his effectiveness in the practice of medicine. Persons chosen to speak on the various subjects and panels are knowledgeable and authoritative on their subjects. Another program designed with YOU in mind, Doctor!

PROGRAM
Wednesday, May 10, 1972
Morning Session

Presiding: W. Thomas Washam, M.D., Chillicothe, Assistant Professor, Department of Preventive Medicine, Ohio State University

"Medical Student Field Assignment: Community Health Rotation — OSU College of Medicine"

9:30-10:15 a.m. Speakers: Robert E. Reiheld, M.D., Orrville, Chairman, OSMA Committee on Rural Health and Martin D. Keller, M.D., Columbus, Professor, Department of Preventive Medicine, Ohio State University

10:15-10:45 a.m. Break for Tour of Exhibits

"OSMA Activities in Professional Standards Review Organization"

10:45-11:15 a.m. Speaker: James L. Henry, M. D., Grove City, Chairman, OSMA Committee on Peer Review; and President of Medical Advances Institute

11:15-11:30 a.m. Question and Answer Period

11:30-1:30 p.m. OMPAC Luncheon — Tickets on sale for $5.00 per person

Speaker: Mr. Robert D. Novak, Washington Columnist and Political Analyst

Subject: **"Politics 1972"**

Wednesday, May 10
Afternoon Session

Presiding: William A. Millhon, M.D., Columbus, President, Ohio Society of Internal Medicine

"Doctor, is an HMO or Medical Foundation a Part of Your Future?"

2:00-2:30 p.m. **HMO's**

Speaker: Vernon E. Wilson, M.D., Administrator, Health Services and Mental Health Administration, Rockville, Maryland; and member of the AMA's Council on Medical Education and of the Liaison Committee on Medical Education

2:30-3:00 p.m. **Medical Foundations**

Speaker: John F. Farrington, M.D., Boulder, Colorado; Board Certified, American Board Internal Medicine; Professional Appointment, University of Colorado School of Medicine and in private practice with the Associated Internists of Boulder

3:00-3:30 p.m. Break for Tour of Exhibits

3:30-4:30 p.m. **Panel Discussion on HMO's and Foundations**

Moderator: William A. Millhon, M.D., Cobus

Panel Participants: Drs. Wilson and Farrington; and Doctors Robert E. Howard, Cincinnati, Chairman, OSMA Committee on Ad Hoc Committee on Health Care Delivery Systems; H. William Porterfield, Columbus, Member, OSMA Committee on Ad Hoc Committee on Health Care Delivery Systems and Stephen P. Hogg, M.D., Cincinnati, Midwest Medical Foundation

Two-Day Clinicopathologic Symposium

Wednesday and Thursday, May 10 and 11
Cincinnati Exposition Center

"CALCIUM — METABOLISM, MEASUREMENT AND MALADIES"

This Symposium is sponsored by the College of American Pathologists (CAP) and the Ohio Society of Pathologists in cooperation with the Section on Pathology of the Ohio State Medical Association. Also a Regional Meeting of the CAP and an Event in the Year of Pathology, 1972.

PROGRAM
Wednesday, May 10
Morning Session

Calcium Metabolism

Presiding: William A. Hawk, M.D., Cleveland, President, Ohio Society of Pathologists, Cleveland Clinic.

9:00 a.m. **Introduction to Symposium**—Robert C. Horn, M.D., Vice President, College of American Pathologists, Henry Ford Hospital, Detroit, Michigan.

9:15 a.m. **Calcium Homeostasis—An Overview** —Thomas G. Skillman, M.D., Professor of Medicine and Director of Endocrinology and Metabolism, Ohio State University College of Medicine, Columbus.

9:45 a.m. **Parathormone — Its Physiological Role and Clinical Significance** — Richard E. Goldsmith, M.D., Professor of Medicine, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati.

10:15 a.m. Break to View Exhibits

10:45 a.m. **Thyrocalcitonin — Its Physiological Role and Clinical Significance** — Paul L. Munson, Ph.D., Professor of Pharmacology and Endocrinology, Chairman, Department of Pharmacology, University of North Carolina at Chapel Hill, North Carolina.

11:15 a.m. Panel Discussion — Questions and Answers

Moderator: J. Beach Hazard, M.D., Formerly Chairman of the Division of Laboratory Medicine, Cleveland Clinic, Cleveland.

Panelists:
Richard E. Goldsmith, M.D.
Paul L. Munson, Ph.D.
Thomas Skillman, M.D.

Wednesday, May 10
Afternoon Session

Calcium Measurement

Presiding: Lawrence J. McCormack, M.D., Speaker of the House of Delegates, College of American Pathologists, Cleveland Clinic, Cleveland.

1:30 p.m. **The Reliability of Calcium Measurement in the U.S.A. Today** — Roger K. Gilbert, M.D., Member, Survey Committee, College of American Pathologists, Director of Laboratories, Waterbury Hospital, Waterbury, Connecticut.

2:30 p.m. Break to View Exhibits

3:00 p.m. **Assurance of Quality — The Practical Role of the CAP** — Pierre W. Keitges, M.D., Member of Standards Committee of the CAP, Menorah Medical Center, Kansas City, Missouri.

4:00 p.m. Discussion

Thursday, May 11
Morning Session

Calcium Maladies: Nine CPC's in Miniature

Panel Discussion

Moderator: J. Beach Hazard, M.D.

Panelists:
Robert Allman, M.D. (Associate Director of Section of Radiology, Armed Forces Institute of Pathology, Bethesda, Maryland)
Richard E. Goldsmith, M.D.
Paul L. Munson, Ph.D.
Thomas G. Skillman, M.D.

9:00 a.m. Cases 1, 2 and 3

10:15 a.m. Break to View Exhibits

10:45 a.m. Cases 4 and 5

11:30 a.m. Business Meeting, Ohio Society of Pathologists

Thursday, May 11
Afternoon Session

2:00 p.m. Cases 6 and 7

3:00 p.m. Break to View Exhibits

3:30 p.m. Cases 8 and 9

Art Show Planned
FOR 1972 OSMA ANNUAL MEETING

Space will be provided at the 1972 Annual Meeting of the Ohio State Medical Association, May 9, 10 and 11, at Cincinnati Convention Center for a Physicians' Art Show. The Medi-Art Club of the Academy of Medicine of Cincinnati will merge their annual art exhibit with that of the Ohio State Medical Association at its annual meeting.

Members of OSMA and their wives interested in exhibiting pieces and requiring information regarding this can contact:

Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

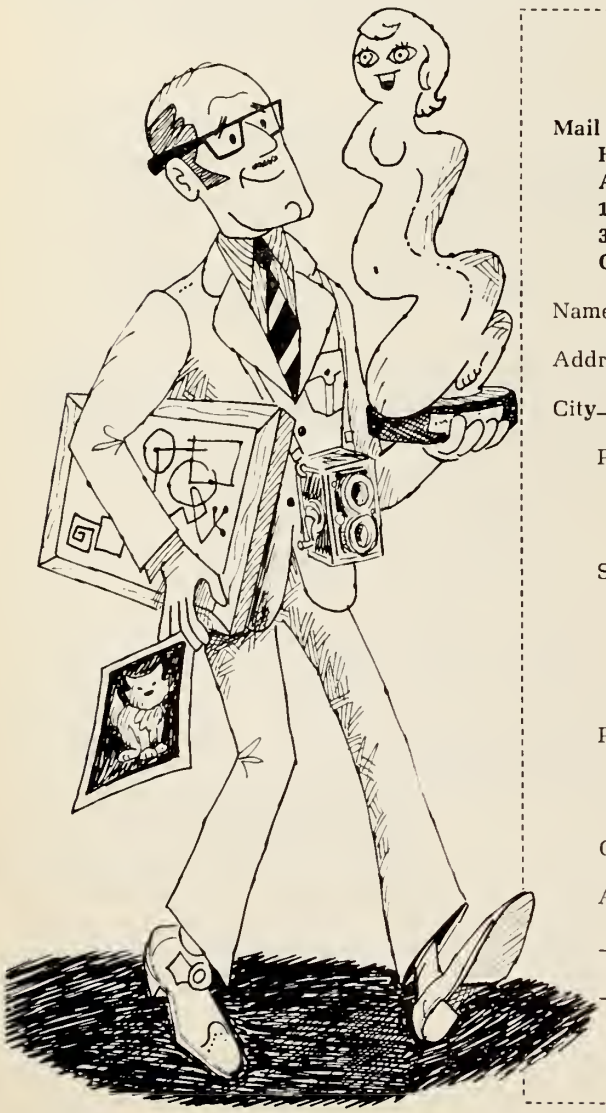
It will be the responsibility of each physician to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expenses involved in entering his or her exhibit.

Exhibitors will be limited to two art pieces per person. Please list in order of preference to be exhibited.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibit to make this an outstanding Art Show.



Application for Space in Art Show Exhibit

Mail to:
Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

Name_____

Address_____

City_____

Photography (must be mounted) _____

_____
(give dimensions)

Sculpture _____

_____
(give estimated size)

Check one: ☐ Pedestal type ☐ Wall type

Painting _____

_____
(give dimensions: depth, width and height)

Other information (which you believe will be helpful to the Art Committee) _____

_____

_____

(Deadline on Art Application to be announced)

Old winner, new bottle.



DBI® phenformin HCl tablets of 25 mg.
DBI-TD® phenformin HCl capsules of 50 and 100 mg.

Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

Contraindications: Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoglycemia.

Warnings: Use during pregnancy is to be avoided.

Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**

2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.

3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(B)98-146-103-C

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502
Distributors

DBI-8345-9



Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with: the common cold, acute and chronic sinusitis, vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component; concurrent MAO inhibitor therapy; severe hypertension; bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

SK&F *Smith Kline & French Laboratories*

Trademark

ORNADE® SPANSULE®

brand of sustained release capsules

Each capsule contains 8 mg. of Teldrin®(brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

UNCOMMON RELIEF FOR COLD SYMPTOMS

OR-203

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Empirin Compound with Codeine relieves aches, pains, fever and general malaise of colds and of FLU

A gratifying announcement about Empirin® Compound with Codeine

CIII

You may now specify up to five refills within six months when you prescribe Empirin Compound with Codeine (unless restricted by state law).

It is significant in this era of increased regulation, that Empirin Compound with Codeine has been placed in a less restrictive category. You may now wish to consider Empirin with Codeine even more frequently for its predictable analgesia in acute or protracted pain of moderate to severe intensity.

Empirin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.



When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

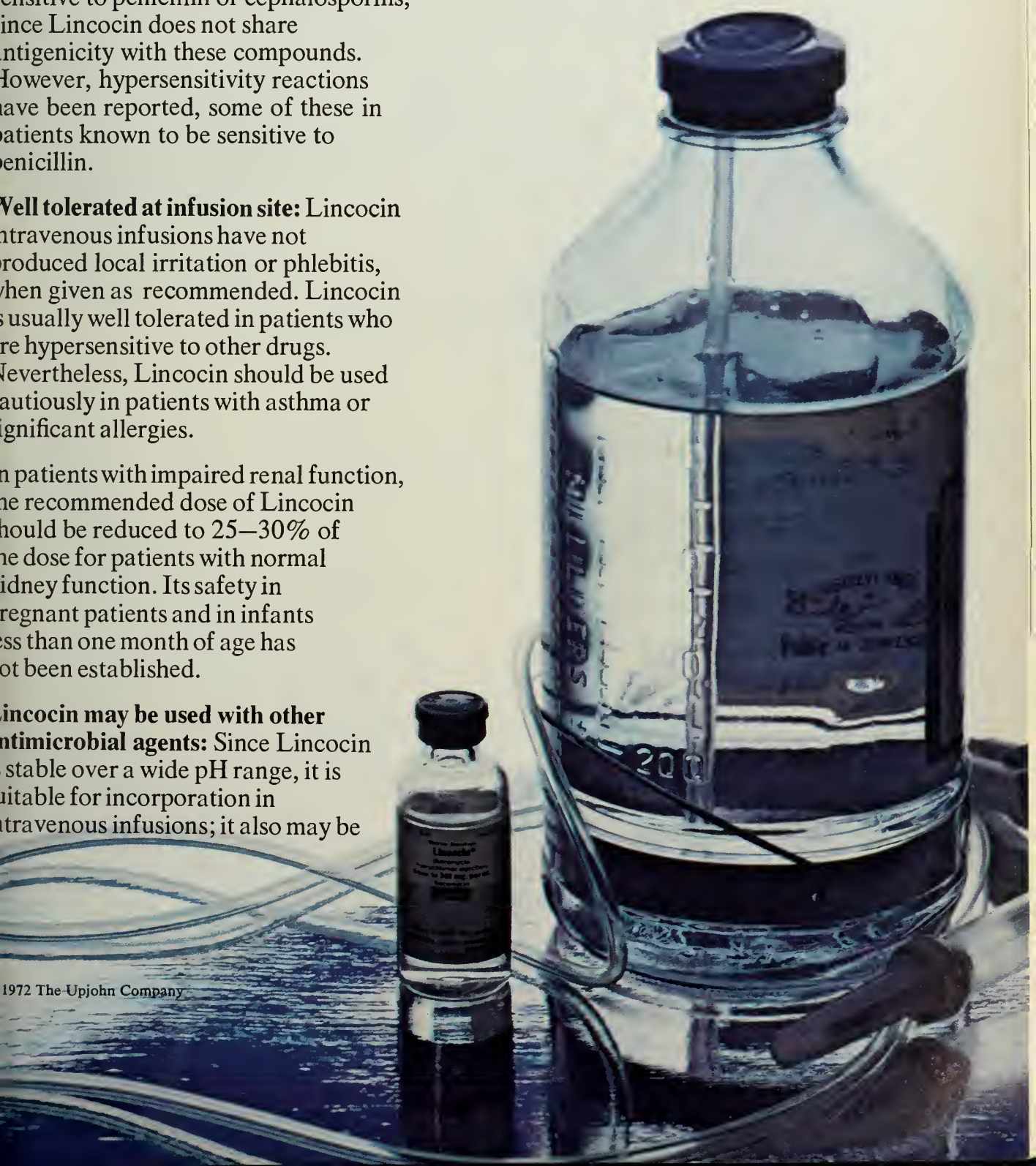
Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



© 1972 The Upjohn Company



Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 mg* Capsules—bottles of 24 and 100. *Sterile Solution, 300 mg per ml*—2 and 10 ml vials and 2 ml syringe. *Syrup, 250 mg per 5 ml*—60 ml and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-6-S (KZL-7) JA71-1631

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Kalamazoo, Michigan 49001

Upjohn

INSIDE REPORT

Politics 1972

As a supporter of the Ohio Medical Political Action Committee and the American Medical Political Action Committee, you'll want to attend the . . .



ANNUAL OMPAC LUNCHEON

WEDNESDAY, MAY 10, 1972
(week of the OSMA Annual Meeting)

CINCINNATI EXPOSITION CENTER

Speaker...

Washington Columnist and Political Analyst

ROBERT D. NOVAK

Some facts about Mr. Novak...

If you will recall, Mr. Novak was the OMPAC speaker for the 1970 Annual Meeting and by popular demand is returning as our guest speaker at the 1972 OMPAC Luncheon. If you did not hear Mr. Novak in 1970 don't miss attending the 1972 OMPAC Luncheon. A treat will be in store.

In 1957, the Associated Press named him Capitol Hill correspondent in Washington, D.C. He joined the Wall Street Journal in 1958 as Senate correspondent and political reporter, and in 1961 became chief Congressional correspondent for the Journal.

In May 1963, Mr. Novak teamed with Mr. Rowland Evans, Jr. to write INSIDE REPORT, a political column, published five times a week. It is noted for its emphasis on reporting rather than punditry, and its rapidly moving dateline.

OMPAC LUNCHEON RESERVATION

WEDNESDAY, MAY 10, 1972 – 11:30 A.M.

Enclosed is $_____ to pay for:

_____ OMPAC Luncheon tickets @ $5.00 per person

Name:_____

Street Address:_____

City:_____

(Please pick up tickets at OSMA Registration Desk)

Mail to: Ohio State Medical Association, 17 South High Street, Suite 500
Columbus, Ohio 43215

The Woman's Auxiliary and Plan a FUN EVENING

– A – B

Tuesday Evening, May 9

The Medi-Art Club of the Academy of Medicine of Cincinnati and the Woman's Auxiliary to the Ohio State Medical Association have arranged a choice of activities for your free time on Tuesday, May 9. You can watch a ball game, absorb a bit of culture, or have a nightclub fling — all in new downtown Cincinnati. Take your pick and sign up for one of the events outlined on these pages.

A is for ART---

(Plan A)

Cash Bar at 6:00 p.m., followed by Dinner at 7:00 p.m.

To be held in the Academy Building, First Floor, 320 Broadway, Cincinnati.

Price: $7.00 per person (Use coupon below and make checks payable to the Medi-Art Club).

B is for BALL---

(Plan B)

Have strip steak dinner in the Medi-Club, 320 Broadway (lower level) and walk over to Riverfront Stadium to see the Cincinnati Reds vs Chicago Cubs.

Time: Dinner at 6:00 p.m.; Ball game at 8:05 p.m.

Your Hostess: Mrs. Dale R. Wiethe.

LIMITED to 60 persons; advance sale only for dinner-ball game package.

Price: $10.50 per person (includes tax and tip).

Reservation for Plan A

Price: $7.00 per person _____ Number of persons

(Make checks payable to the Medi-Art Club)

Mail Reservations to: Harry H. Fox, M.D.
Medi-Art Club, Inc.
320 Broadway
Cincinnati, Ohio 45202

Enclosed is $_____ No Cancellations will be Accepted.

Name_____

Address_____

Reservation deadline — May 1

Medi-Art Club of Cincinnati

in just three easy steps–

– C

C is for CLUBBING AROUND---

(Plan C)

Have prime rib dinner at the Lookout House in Northern Kentucky. See the floor show featuring Lou Rawls; have one drink on the house. Continue on to the Playboy Club for the late floor show and two drinks.

Time: A chartered bus will pick you up at the Terrace Hilton at 7:00 p.m. and will also transport you from one Club to the other. You can walk back to your hotel from the Playboy on 7th Street and so can set your own curfew!

Your Hostess: Mrs. Constandinus Condorodis.

LIMITED to 50 persons; advance sale only for Night-Club Tour.

Price: $23.00 per person (includes tax and tip).

Reservation for Plans B and C

Make checks payable to: (Auxiliary Convention Fund)

Mail to: Mrs. Edward J. Bender
3610 Clifton Avenue
Cincinnati, Ohio 45220

(Plan B) Dinner and Ball game @$10.50 per person _____ Number

(Plan C) Dinner and Night-Club Tour @$23.00 per person _____ Number

Enclosed is check for $_____

Name_____

Address_____

Please clip and mail to Mrs. Bender

Tickets may be picked up at the Auxiliary Registration Desk in the lobby (8th floor) of the Terrace Hilton on Tuesday between 12 Noon and 3:00 p.m. Deadline for advance registration is May 1. If the limit is reached before your reservation arrives, your check will be returned to you.

ON THE OMPAC FRONT

Labor, Business, Teachers On the Ball; OMPAC Dare Not Drag Its Feet

The AFL-CIO which wants a National Health Insurance Program like the shoot-the-works Kennedy proposal, according to Dale McFeatters, Scripps-Howard staff writer, is seeking to more than double for the 1972 political campaigns, the estimated $6 million, or more, in voluntary contributions it plowed into the 1968 election campaigns. Also, the AFL-CIO is involved in registering young voters on the theory that seven out of 10 signed up will vote labor's choice. Retired union members are being organized and the rank-and-file is being urged to register.

★ ★ ★

Delegates to the Special Representative Assembly of the Ohio Education Association which is composed of at least 100,000 teacher-members recently approved a resolution supporting the immediate establishment of an independent, voluntary political action organization for educators in Ohio. A group headed by several past presidents of the organization known as EPAC (Educators Political Action Committee), is currently in the formation stage, i.e., setting up guideline, organization of a statewide steering committee and picking names for local committees. Commenting on the potential influence of the EPAC, one of its organizers observed that it could raise a statewide budget of at least half a million dollars with an upper level, perhaps of three or four million dollars a year. EPAC says its number one purpose is to "solicit, collect and distribute campaign funds to the friends of education and to help in the campaigns of the friends of education through political education, voter registration drives, and all of the other things that a politically oriented group gets into."

★ ★ ★

Indications are that businessmen are continuing their commitment to political activity, reports the Business-Industry Political Action Committee in its bulletin *Politics*. The percentage of current members who are renewing for the year has been high and the most progress appears to have been in enlisting new members, the publication points out. Quoting the BIPAC president on the 1972 situation: "It will be the most important and most complex political year in our experience. 1972 will be a whole new ball game."

★ ★ ★

AMPAC-OMPAC which represents the medical profession in the political arena is now getting ready for one of the most crucial challenges it has ever faced—the 1972 General Election. **AMPAC-OMPAC must keep pace with labor, business, educators and other groups in their efforts to play a vital political role this coming fall.** AMPAC-OMPAC wants to help men and women of intelligence, integrity and with known sound views on social and economic issues win public office. All it asks in return of such persons, if elected, is that they at **least listen to medicine's spokesmen on pending legislation.**

AMPAC-OMPAC needs money now to get its wheels moving. Membership brings in money. Membership is the life blood of AMPAC-OMPAC. If it has money, it lives. If it lacks money, it will perish. If it has some money but not enough, it suffers from anemia.

Have you made your AMPAC-OMPAC contribution for 1972? If not, see your local medical society secretary-treasurer now.

—Ohio Medical Political Action Committee

Deadline for Submission of Resolutions to OSMA Office is March 9

Delegates to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1972 Annual Meeting should be guided by the following requirements of the Bylaws:

Resolutions, regardless of whether they have been submitted in advance must be introduced at the first session of the House of Delegates, Monday morning, May 8, at the Cincinnati Exposition Center.

To be eligible for presentation, a resolution must be filed with the Executive Director of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely not later than March 9. This requirement may be waived by a two-thirds majority of the House of Delegates.

Copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

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Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

"... there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

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OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

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Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *ij* tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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Obituaries

Adam Gruver Allen, M.D., Dayton; University of Cincinnati College of Medicine, 1937; aged 63; died December 31; member of OSMA, AMA, and American Psychiatric Association; diplomate, American Board of Psychiatry and Neurology; practitioner in the Dayton area for 18 years, specializing in psychiatry; veteran of World War II. Dr. James S. Allen, of Akron, is his son.

Edward V. Bennett, M.D., Dayton; Meharry Medical College School of Medicine, 1944; aged 52; died January 11; member of OSMA and former member of AMA; member of National Medical Association; practitioner in the Dayton area since 1952, specializing in general surgery.

Frank C. Clifford, M.D., Toledo; St. Louis University School of Medicine, 1921; aged 76; died December 30; member of OSMA, AMA, American Society of Internal Medicine; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner in the Toledo area since 1922, specializing in cardiology; former secretary and member of the council of the Academy of Medicine of Toledo, and former editor of its *Bulletin.*

Erwin Leroy Conry, M.D., Lakewood; University of Nebraska College of Medicine, 1942; aged 62; died January 19; member of OSMA, AMA, and American Academy of General Practice; practitioner in the Cleveland area since 1945; veteran of World War II.

Thomas Hugh Davis, M.D., Tulsa, Oklahoma; University of Cincinnati College of Medicine, 1924; aged 72; died in December; practitioner in Tulsa for some 40 years.

Nathan Joshua Epstein, M.D., Cleveland; George Washington University School of Medicine, 1921; aged 79; died January 1; member of OSMA and AMA; general practitioner in the Cleveland area for 50 years.

Frank Fenton Ferris, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1902; aged 99; died January 16; member of OSMA and AMA; practitioner for many years in the Cincinnati area, specializing in the EENT field; veteran of World War I.

Leonard Arnold Hautzenroeder, M.D., Mansfield; University of Cincinnati College of Medicine, 1935; aged 63; died January 1; member of OSMA and AMA; general practitioner and general surgeon in Mansfield for 33 years; veteran of World War II.

Joseph Byrne Kallenberg, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1938; aged 62; died December 29; member of OSMA, AMA, the American Academy of Family Physicians, and American Geriatrics Society; general practitioner in Cincinnati for more than 30 years.

(Continued on Next Page)



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Frank J. Keeley, M.D., Cleveland; Queen's University Faculty of Medicine, Canada, 1907; aged 89; died December 25; former member of OSMA; retired in 1960 after practicing for more than 50 years in the Cleveland area.

Victor L. Koby, M.D., Cleveland; medical degree from the University of Prague, 1949; aged 59; died January 15; member of OSMA and AMA; diplomate, American Board of Psychiatry and Neurology; came to this country in 1950 and practiced for a number of years in Cleveland where he specialized in psychiatry.

Rollin William Kuebbeler, M.D., Toledo; University of Cincinnati College of Medicine, 1931; aged 68; died January 11; member of OSMA and the American Academy of Family Physicians; lifelong resident of the Toledo area; general and industrial practitioner there for some 40 years. Dr. Philip L. Kuebbeler, of Toledo, is a son.

Joseph Anthony Muenzer, M.D., Toledo; St. Louis University School of Medicine, 1918; aged 77; died December 27; member of OSMA, AMA, and American Academy of Family Physicians; general and industrial practitioner in Toledo for some 49 years; former member of the State Silicosis Commission; veteran of World War I.

Charles Stewart Noonan, M.D., Cincinnati; University of Cincinnati College of Medicine, 1919; aged 90; died January 5; member of OSMA and AMA; general practitioner and internist in Cincinnati for more than 50 years.

Frank Seinsheimer, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 70; died January 24; member of OSMA, AMA, and American Academy of Pediatrics; diplomate, American Board of Pediatrics; assistant professor of clinical pediatrics at the University of Cincinnati; practitioner in Cincinnati for 45 years.

Eugene John Shanahan, M.D., Clyde; St. Louis University School of Medicine, 1926; aged 72; died January 21; former member of OSMA; general practitioner in the Clyde area for 40 years; veteran of both World Wars I and II.

Maurice Lynn Snell, M.D., Akron and Barberton; University of British Columbia Faculty of Medicine, 1950; aged 52; died December 24; member of OSMA, AMA, and American Society of Clinical Pathologists; Fellow, College of American Pathologists; diplomate, American Board of Pathology; director of pathology at Barberton City Hospital for nine years.

Thomas Henry Sutherland, M.D., Marion; Johns Hopkins University School of Medicine, 1923; aged 73; died January 12; former member of OSMA; member of the Aerospace Medical Association; diplomate, American Board of Preventive Medicine; practitioner for many years in Marion; former lecturer in medical law at Ohio State University; active for many years in the Flying Physicians organization.

Ronald Wilmer Thompson, M.D., Akron; University of Nebraska College of Medicine, 1938;

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aged 57; died January 15 as the result of a fire in his home; member of OSMA and AMA; practitioner in Akron for about 26 years, specializing in internal medicine. Mrs. Thompson died also as a result of the fire.

Joseph Frederick Toot, M.D., Canton; Harvard Medical School, 1921; aged 76; died January 16; member of OSMA, AMA, and American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Ophthalmology; practitioner in the Canton area for more than 50 years.

Walter Bird Turner, M.D., Youngstown; Indiana University School of Medicine, 1909; aged 88; died January 30; member of OSMA and AMA; diplomate, American Board of Surgery; practitioner in Youngstown beginning in 1911, specializing in surgery and industrial medicine.

Robert Edmund Wolf, M.D., Urichsville; Eclectic Medical College, Cincinnati, 1924; aged 74; died January 23; member of OSMA and AMA; general practitioner in the Urichsville area for many years; veteran of World War II.

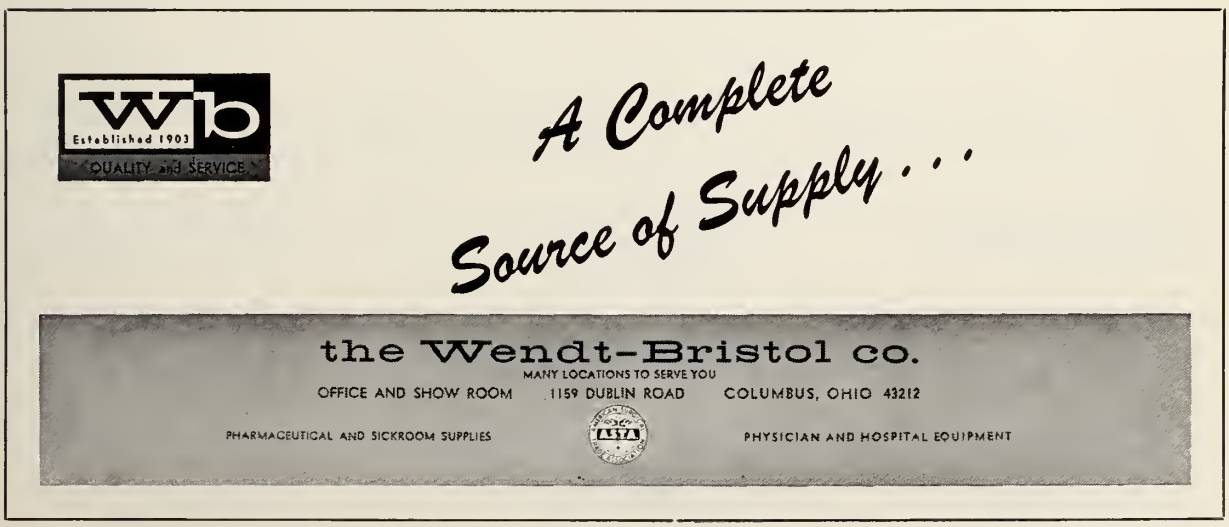
Self-Teaching Library Established in Cincinnati

Based on the philosophy that one learns by being actively involved in the learning process, a Self-Teaching Room has been opened in the University of Cincinnati Medical Center library at General Hospital. It is a cooperative effort by all departments of the College of Medicine.

The room will be available to students, housestaff and faculty in the UC Medical Center and members of the medical community. Much of its material has been and will be prepared by the faculty of the College of Medicine.

Books, the traditional repository of educational material, still fill the stacks surrounding the new Self-Teaching Room, but inside "STR" are the tools of modern learning: four carrels for individual study and special equipment. This includes tape-lectures plus slides and radiologic film, 8 mm films from the American Cancer Society, talking-teaching recordings plus film, a heart sound self-teacher and a "cardiogator" for teaching audible components of the cardiac cycle.

Dr. Robert Adolph, professor of medicine, heads up the project. Funds are provided by various departments and by the Roche Foundation.



Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

See it, peeking over the horizon? Feel it in the air? Hear the echo of terrific activity from Cincinnati? Note the vibrations of expectancy all over the state? Sure 'nuff! It is getting closer and closer — and what else could I be meaning but Convention Time? It won't be too long now — that 32nd annual convention of the Woman's Auxiliary to the Ohio State Medical Association, with headquarters at the Terrace-Hilton Hotel.

Scheduled for the merry month of May (and as I write this in the icy depths of February, it looks like a little bit of Heaven) the 1972 annual meeting will be neatly fitted into three special days — Tuesday, May 9, Wednesday, May 10 and Thursday, May 11. For Board members (outgoing and incoming) as well as for 1972-73 county presidents and presidents-elect, it will mean three days of participation. For other delegates, it will mean two days of participation. Here's the way it breaks down:

Tuesday morning at 9 a.m. will witness the convening of the 1971-72 Board, as well as a "first" — the presence of the new 1972-73 Board — at this preconvention Board meeting. At the 12:30 p.m. luncheon that day, it is hoped that each "old" chairman will have the opportunity to lunch with her successor and brief her on that particular job for the next Auxiliary year. At 2:30 p.m. Tuesday afternoon, another "first" (to the best of my knowledge!): a mini-conference for 1972-73 county presidents and presidents-elect with state officers. This can be a golden opportunity for the helpful and intelligent charting of the year ahead.

Socially Speaking

Tuesday evening, May 9, looms ahead in mighty interesting fashion. "An Evening in Downtown Cincinnati" has many facets. The convention committee is offering a choice of activities, but it is important to point out that each is limited as to attendance **with advance reservations an absolute must.** "The magnificent new Riverfront Stadium," writes Fran Krone, convention chairman, "is right there in the heart of town, within walking distance of many of the restaurants and hotels. And the Cincinnati REDS have a game scheduled for this very evening (not especially for our benefit!) but isn't this a great coincidence! We have arranged a dinner-ballgame package as one of our suggested activities for that night. There will be a strip steak dinner at six o'clock at the Medi-Club (the social club of Cincinnati's Academy of Medicine) and then a walk of just a few short blocks to the Stadium for the game between the Reds and the Chicago Cubs at 8:05 p.m. Incidentally, there is a bar at the Medi-Club which will be open to convention guests at any time.

"Since Cincinnati is the only city in Ohio that has a PLAYBOY CLUB (I think!), our com-

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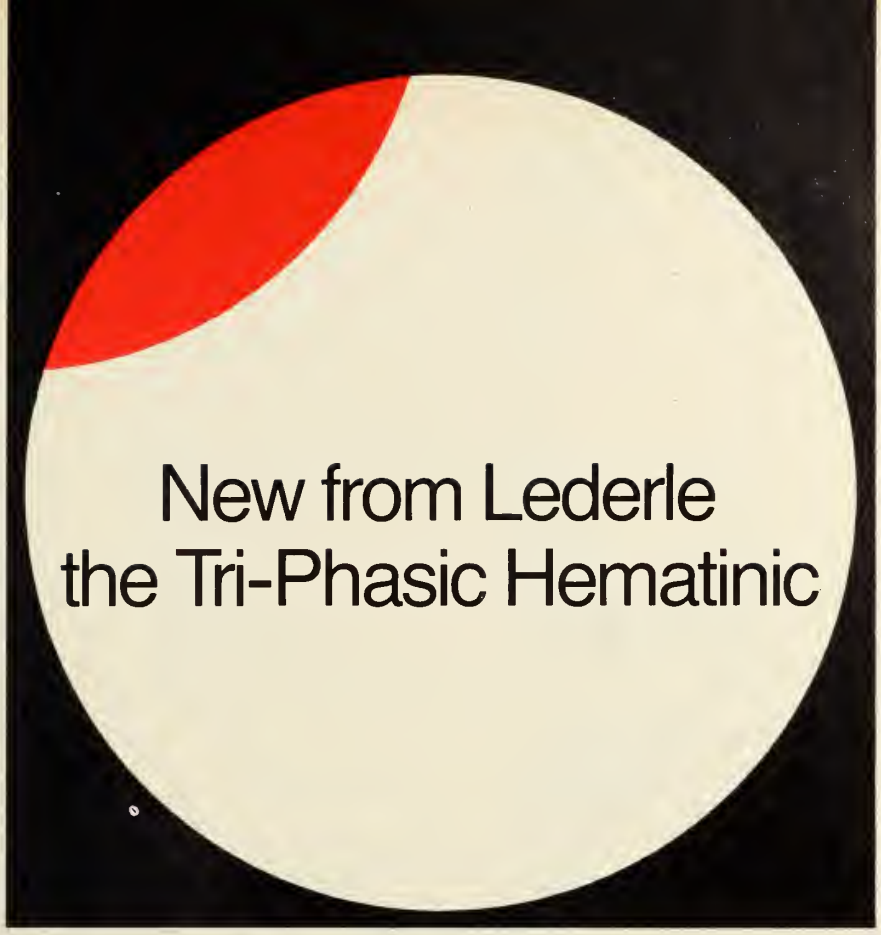
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Intrinsic Factor Concentrate	75 mg.
Folic Acid	1 mg.
Vitamin E (*d*-Alpha Tocopheryl Acid Succinate)	30 Int. Units
Elemental Iron (as present in 350 mg. of Ferrous Fumarate)	115 mg.
Dioctyl Sodium Sulfosuccinate U.S.P.	50 mg.

Dosage: One Tablet Daily.
Available in Bottles of 30 Tablets.
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Precautions: Some patients affected with pernicious anemia may not respond to orally administered Vitamin B_{12} with intrinsic factor concentrate and there is no known way to predict which patients will respond or which patients may cease to respond. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended. If any symptoms of intolerance occur, discontinue drug temporarily or permanently. Folic acid, especially in doses above 1 mg. daily, may obscure pernicious anemia, in that hematologic remission may occur while neurological manifestations remain progressive.

Adverse Reactions: G.I.: nausea, vomiting, diarrhea, abdominal pain. Skin rashes may occur. Such reactions may necessitate temporary or permanent changes in dosage or usage. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

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421-

mittee thought there would be those who might prefer to go night-clubbing, rather than see a ball game. Here again, there is a 'package plan'. A chartered bus will pick up such persons at the Terrace Hilton at seven p.m. and take them first to the LOOKOUT HOUSE in northern Kentucky, just across the river. Two attractions (no, three!) are offered: a drink on the house, a prime ribs dinner and a floor show featuring Lou Rawls. Then, back on the bus and over to the PLAYBOY CLUB for a couple of drinks and another floor show. The advantage of this 'package plan' is that it eliminates cover charges, tax, tips, etc., and includes transportation, therefore no parking worries! The PLAYBOY CLUB will have matchbook favors with OSMA printed on them, and will extend the privileges of the club to convention guests."

Fran Krone further points out that for those more interested in Cincinnati's cultural offerings, there are many other possibilities for the convention guest's free time. The Medi-Club has planned a dinner with an outstanding speaker on art. Details on all this will be found on another page of this issue of the *Ohio State Medical Journal,* along with an advance reservation order form. This dinner art event is also scheduled for Tuesday evening, since Wednesday night is reserved exclusively for the gala "Riverboat Odyssey," sponsored by OSMA.

"Stop and Swap"

"Stop and Swap" is scheduled for the Thursday morning Breakfast Session — essentially a sharing of program ideas. **This does not replace in any manner, shape or form the traditional Wednesday afternoon reports by the county presidents.** The Thursday morning "special" is to feature a variety of ideas — such as a county's most successful or most thought-provoking program or activity that has been based on particular and pertinent interests or problems. In order to avoid duplication, the convention committee will choose the programs to be presented.

A letter has gone out to all county presidents, asking for their participation. In the words of the committee: "This is your chance to brag about your county's accomplishments." It is hoped that the county auxiliaries will respond in full measure to what can prove to be of tremendous value. After all, from shared experiences come new insights.

The regular convention pattern for Wednesday and Thursday remains: two morning business

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...s, the Wednesday afternoon county presi... report session, the Thursday reception for the incoming officers and Board, a closing luncheon and the post convention board meeting. More on all that next month . . .

Hotel Reservations

Auxiliary headquarters, I repeat, will be at the Terrace Hilton Hotel, Sixth Street between Vine and Race Streets. The cut-off date on reservations for rooms there will be April 25th. However, the management says that it will accept reservations up to May 9th, depending on room availability. Based on past experience, I suggest that reservations be sent in as early as possible. The Terrace-Hilton has a way of filling up fast!

Room rates are: for singles; $18, $19, $20, $21 and $35; doubles or twins: $24, $25, $26, $27 and $35; suites, $35 and up. All rates are subject to state and local taxes which currently total 7½ percent.

Next month there will be further information on the convention detailed in this column. Remember, come May, that all roads lead to Cincinnati. Be sure you travel one of them . . .

"Due" It, Please!

An urgent plea has reached me from Mrs. Paul Hahn, state treasurer. She reminds auxiliary members that the deadline for state dues and for counties to have representation and voting privileges at the state convention was February 15th. It's a bit late, I realize, for reminder on that now. However, it isn't too late for Mrs. Hahn to send in National dues so that Ohio may have the largest number of eligible voters possible at the National Convention (the number of delegates allowed for national convention is based on a state's total membership). That target date is March 15th. June 15th, says Mrs. Hahn, is the last possible date on which she can accept dues, as she has to have them in to National "absolutely no later than." It is important to remember that Ohio's fiscal year is from June 30 to June 30.

One other important reminder coming from Jo Hahn: names of deceased members for this auxiliary year must be in to her no later than **April first,** if those names are to be printed in the state convention program. "I don't know," writes Mrs. Hahn, "if very many of our members are aware that these names are also sent to National to be included in its Memorial Booklet."

OMPAC-AMPAC

Traditionally the month of March has meant, for auxiliary members, enrollment time in the Ohio Medical Political Action Committee. Mrs. Malachi W. Sloan, II, state legislative chairman, turns the spotlight on in that direction, reminding our membership that:

Twenty-five dollars buys an OMPAC-AMPAC membership and guarantees — 1) Dollars for men and women, Republican or Democrat, (seeking election on a state or national level) who best represent medicine's interests; 2) Medicine will be heard when legislation is written. OMPAC-AMPAC select the best qualified public servants to do the job; 3) All candidates to be supported by PAC have been screened by the Ohio Committee on the recommendation of local groups of doctors; 4) No PAC money is used in primary election campaigns; 5) $10 of your contribution goes to the American Medical Political Action Committee (AMPAC); $15 to the Ohio Medical Political Action Committee (OMPAC).

Jane Sloan sends this personal message to auxiliary members: "Your contribution is a real



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

bargain for it will pay large dividends in November, 1972. The emphasis in auxiliary activity this year is on legislation and this is a great way to be where the action is . . ."

Registered?

Mrs. Sloan also asks that question. Are you registered to vote? If you have moved recently, or if you have not exercised your voting privilege for the last two years, you must check in at your local Board of Elections and re-register, if you want to vote in the November elections. Don't delay — do it today! **Last date for registering is April 2 (for the Primaries).** Don't throw away the privilege that is yours as an American citizen.

Help Wanted!

Do you have stationery, a pen (or typewriter) and a little time? If we may be forgiven for this bit of paraphrasing: Now is the time for all good women to rise and speak for medicine and the men who practice medicine . . . What's it all about?

Back in October, the House Ways and Means Committee opened hearings on the bill H.R. 4960 which we know as Medicredit. The question is no longer whether or not we want such a program, but rather that we have a program the doctors can live with. Senator Edward Kennedy's bill has a price tag upwards of $45 billion and a whole new method of delivery of health service. The AMA-sponsored bill — H.R. 4960 (Medicredit) is priced at less than $12 billion. Medicare would not be changed under this bill but Medicaid would be dropped.

Auxiliary members and their friends are urged to write to one or all of the following members of the committee (please note that the letter designated before the name indicates where the letter or card is to be sent, i.e., C—Cannon House Office Building; R—Rayburn House Office Building; L—Longworth House Office Building—Washington, D.C. 20515:

Democrats: L—Wilbur D. Mills, chairman; R—Al Ullman; C—James Burke; L—Martha W. Griffiths (co-sponsor of Kennedy proposal); R—Dan Rostenkowski; R—Phil Landrum; R—Charles Vanik (Ohio); C—Richard Fulton; R—Amor Burleson; C—James Corman; L—William Green; C—Sam M. Gibbons; C—Hugh L. Carey; C—Joe D. Waggonner; R—Joseph E. Karth.

Republicans: R—John Byrnes; R—Jackson E. Betts (Ohio); L—Herman Schneebli; L—Harold R. Collier; R—Joel T. Broyhill; C—Barber B. Conable, Jr.; R—Charles E. Chamberlin; C—Jerry Pettis; C- John J. Duncan; C—Donald G. Brotzman.

It is suggested that the letter or card sent to one or more of the above mentioned Congressmen be simple, that you state your concern for Health Care **as a citizen and not as the wife of an MD.** Ask the man's consideration of the principles set forth in the AMA Medicredit proposal (use the title H.R. 4960—National Health Insurance Act of 1971).

Talk to your friends about this. Get started on writing your own cards or letters—not tomorrow but TODAY. Get going—and keep going!

Here and There

The **Montgomery County** auxiliary held its Christmas luncheon and meeting at the Peerless Mill Inn in Miamisburg. Among the group's past presidents honored that day were: Mrs. Wallace Taggart, Mrs. John Pruzzo, Mrs. Robert Zipf, Mrs. Harvey Staton, Mrs. Clarkson Payne, Mrs. John Duchak, Mrs. Malachi W. Sloan, Mrs. Jack Weiland, Mrs. Conrad Kircher, Mrs. Wallace Smith, Mrs. Herman Lubens and Mrs. Sylvan Weinberg.

Scioto County's December meeting was an afternoon tea at the home of Dr. and Mrs. Clyde



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Hurst. At the short business session, members for the Nominating Committee were elected. The program featured "Christmas In Other Lands." A letter from Project Hope was read, thanking the Scioto auxiliary for the orthopaedic shoes project in which it is engaged for the benefit of Hope. "Please be assured that these shoes will be put to good use in our Orthopaedic Department on board the S. S. Hope," wrote the special assistant in Hope's Division of Logistics.

The **Huron County** auxiliary held its December 10 meeting at Fisher-Titus Hospital in Norwalk. Each member invited one or more guests for this special occasion at which James Imboden, field representative for the American Medical Association was the featured speaker. Mr. Imboden showed a film strip on the Medicredit plan of the AMA for Health Care. Following the film strip, there was a question and answer period. Refreshments were served from a table decorated in the Christmas motif.

Training Program for Directors of Medical Education

A Training Program for Directors of Medical Education has been developed by the Continuing Education Program of the Ohio State Regional Medical Program.

The Training Program is based upon the concept that community hospitals are educational institutions. There are two principles implicit in this concept: (1) any place where medical care is rendered must be a place where learning occurs; (2) the quality of care rendered in a hospital is directly related to the quality of the educational program in that hospital. It is a basic three-month program with an optional, but highly recommended fourth month Preceptorship with an experienced Director of Medical Education in a community hospital.

The Training Program deals specifically with three areas: (1) educational activities, (2) interrelationships between education and other hospital activities, and (3) collateral activities.

A systematic approach to developing education programs in community hospitals is stressed. Training is both didactic and experience-centered with two-way continuous feedback and evaluation.

The first few weeks are spent becoming knowledgeable about the role of the Director of Medical Education in a community hospital, including the functions and responsibilities as well as requirements in terms of behavioral characteristics—art of communication, interpersonal relationships, maturity of judgment and self-concept.

Whenever possible, a patterned learning sequence is followed. However, the available time devoted to the program by cooperating Directors of Medical Education varys as will the available time of consultants in Education and the Behavioral Sciences. Conferences, seminars and selected professional meetings also influence the sequence to some degree. However, all areas described in an accompanying syllabus are covered during the Trainee's program.

In addition to attending conferences and seminars, the Trainee works with the Center for Continuing Medical Education of The Ohio State University to learn methods and techniques for developing such programs.

Much of the time in the latter part of the Training Program is spent with cooperating Directors of Medical Education in community hospitals. If the trainee elects to take the highly recommended fourth month of the Program, he will spend the entire time with one experienced Director of Medical Education in a community hospital.

The tuition for the Training Program is $500.00 per month, and in addition to program content, the fee includes guest faculty parking permit, library privileges, recreation card, desk space, secretarial assistance, travel expenses to program-related conferences and seminars (off-campus), consultants' honoraria, membership dues in medical education organizations, certain journal subscription fees and selected textbooks with which to begin a core library in the field of medical and allied medical education.

For further information, contact Donald E. McBride, D.O., Associate Director, Continuing Education Program, Ohio State Regional Medical Program, 320 West Tenth Avenue, Columbus, Ohio, 43210.

Bellaire Physician Named President of State Medical Board of Ohio

Peter Lancione, M.D., of Bellaire, recently was elected president of the State Medical Board of Ohio, the state agency charged with the responsibility of licensing physicians and other practitioners of the healing arts in Ohio and enforcing the law as it applies to the healing arts.



Peter Lancione, M.D.

Dr. Lancione was appointed to the Board in 1968. He is a native of Bellaire and has been a general practitioner there since 1937, opening his practice there after receiving his medical degree from Jefferson Medical College of Philadelphia and completing an internship at Wheeling Hospital, Wheeling, W. Va.

He has long been a participant in professional activities; is a past president of the Belmont County Medical Society and a past president of the medical staff of Bellaire City Hospital. Among professional affiliations, he is a member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Family Physicians, through affiliation with the Ohio Academy of Family Physicians and the Ohio Valley Academy of Family Physicians. Among statewide activities, he has been on the Membership and Credentials Committee of Ohio Academy of Family Physicians, and has served on the Ohio Board of Rehabilitation. He is a veteran of World War II during which he attained the rank of major.

John D. Brumbaugh, M.D., Akron, was elected vice-president of the Board; Henry A. Crawford, M.D., Cleveland, treasurer; and Henry G. Cramblett, M.D., Columbus, secretary.

Other members of the Board are Ralph K. Ramsayer, M.D., Canton; Anthony Ruppersberg, Jr., M.D., Columbus; James O. Watson, D.O., Columbus; and Frederick T. Merchant, M.D., Marion. William J. Lee, attorney, is the Board's administrator.

Toledo Medical College Construction Progressing

The Medical College of Ohio at Toledo is completing three construction and modernization programs at a cost of $627,000.

The work includes major renovations of two patient areas and a new $439,000 General Services building. Two nursing units in the general hospital have been remodeled to provide greater privacy and up-to-date facilities for 42 patients. Each 21-bed unit contains three private rooms, seven semi-private rooms and one four-bed room. all served by a central nursing station.

The second project is the college's General Services building, a new one-story structure on the east campus. Construction began July 28, 1971.

With 22,440 square feet of floor space, the building is the first structure at the Medical College designed on an "industrial concept." About 80 percent of the area is open space to permit easy adjustment in space allocations for each department.

An estimated 100 persons will occupy the building when the move is completed, freeing space in half a dozen campus locations for added laboratory and teaching facilities.

The third project is the "MCO Clinic" scheduled to open in March. It will contain 26 patient examining rooms, x-ray, pharmacy, diagnostic laboratories and facilities for minor surgery and social service counselling.

Once it becomes fully operational, the MCO Clinic will be able to furnish diagnostic, treatment and preventive-medicine services to more than 2500 patients per month.

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

OHIO, FAIRFIELD, Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

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The Ohio State MEDICAL JOURNAL

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"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized, in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications line in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn, could notify the physicians in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: if drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

ue

Maker of Medicine



Henry W. Gadsden, Chairman & Chief Executive Officer, Merck & Co., Inc.

In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

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Should We Import Canadian-Style Malpractice Defense?

By John H. Lavin
Senior editor, *Medical Economics*

For $35 a year, most Canadian doctors can, in effect, self-insure against malpractice suits. They buy membership in a medical protective association that keeps most M.D.s out of court, defends the few who reach it, and pays all costs.

WHEN U.S. DOCTORS start talking about legal problems, the odds are that one of them has just heard about some new malpractice case. When Canadian doctors get talking about legal problems, the odds are that one of them has just been the recipient of a traffic ticket.

That appraisal, offered by a Canadian Medical Association official recently, sums up the way the malpractice problem affects physicians differently in the two countries. Unlike physicians here, Canadian doctors can practice without the constant threat of malpractice litigation hanging over their heads. And in the relatively rare instances when a Canadian doctor is headed for court on a malpractice charge, he knows he'll have a legal counsel skilled in medicolegal defense, a judge rather than a jury to decide his case, and if he loses, all costs paid, including the award.

That's the fortunate situation for the great majority of Canadian physicians, more than 22,000 of Canada's estimated 27,000 practicing M.D.s. They're members of the Canadian Medical Protective Association, a 70-year-old professional organization—not an insurance company—that steps in whenever a doctor feels legally threatened, whether as a result of patient care or as a result of his work on hospital or medical committees. The cost of membership is $35 a year, half-rate if a physician joins after July 1. And though physicians may also carry malpractice insurance with a commercial carrier, the association notes that, since it has never failed to meet its commitments to its members, doctors don't need it.

Could an organization like the Canadian Medical Protective Association function successfully in the United States? Some physicians here would welcome a chance to find out. But it must be remembered that the legal climate in Canada is somewhat different from that here. Doctrines like res ipsa loquitur—"the thing speaks for itself"—aren't accepted in Canadian courts, and the contingency fee for attorneys, bane of many doctors here, is almost nonexistent in Canada. All of which tends to make Canadian attorneys more reluctant to pursue malpractice charges in court.

Still, only in the last year U.S. physicians saw broad-scale, group-protection programs of malpractice insurance launched by both the A.M.A. and the American Association of Medical Clinics. A proposal to restrict the contingency fee is being aired in at least one state legislature, and medical or medicolegal screening panels are offering no-nonsense alternatives for dealing with nuisance claims. Whether an even harder-line group approach could work here remains to be seen, but U.S. physicians can certainly profit by considering the results of an approach that works successfully for their Canadian counterparts.

Who's Behind the Plan?

The Canadian Medical Protection Association is sponsored by and affiliated with the Canadian Medical Association, Canada's version of the A.M.A. It bills itself as "begun by, owned by, and run by the Canadian medical profession," and membership is open to any physician licensed in the province in which he's practicing, as well as to interns and residents. It offers members these three basic services:

1. Advice about the best way to avoid a suit when threats have been made.
2. Conducting the defense when the threat proceeds to a suit.
3. Payment of all costs and damages, if awarded, subject to association bylaws.

In providing those services, the association takes a hard line with virtually all malpractice

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complaints: no settlements. "We won't contribute one cent to a nuisance settlement," says Dr. T. L. Fisher, secretary-treasurer of the association and one of its prime movers for about 40 years. "And we won't pay for *any* settlement unless the doctor has obviously been guilty of malpractice in its broad sense."

The widespread knowledge of that policy is doubtless one of the factors that's helped keep the Canadian malpractice situation stable. The incidence of suits hasn't risen in Canada in recent years, nor has the amount paid out annually by the association in defense costs and damages. The number of cases that reach the court or settlement stage in any given year in the whole of Canada averages a stunningly low 30. More than half of those are decided in favor of the doctors. In the remaining cases, settlements or awards generally range from almost nothing to about $50,000. In 1961, the association paid out $620,000—$373,000 in damages and $247,000 in costs—as a result of malpractice actions against its members. Seven years later, in 1968, it paid out only $262,000—$123,000 in damages and $139,000 in costs. Even in 1969, when damages and costs far exceeded the previous year, the total came to only $680,000, not much above the 1961 total and far less than some of the single awards in the U.S.

With such statistics, it's not surprising that so-called defensive medicine, often cited in this country, hardly exists in Canada. "Canadian doctors aren't likely to say, 'I'd better do this procedure or test in case I ever get sued,' " says the association's Dr. Fisher. "When our men, prompted by articles in the U.S. journals, ask if they should X-ray in a given situation to protect themselves legally, we tell them: 'Use your clinical judgment. X-ray if you need to. Don't X-ray if the patient doesn't need it. No court is ever going to hold you guilty of failing to do something that was unnecessary.' "

Though membership privileges in the Medical Protective Association don't extend beyond Canada's borders, its system of handling potential malpractice claims might well be considered by doctors here. To begin with, the association continuously advises its physician-members to contact it as soon as they recognize significant dissatisfaction on the part of a patient. So any morning's mail may bring to Dr. Fisher's desk one of the 450 or so letters that come in annually from members. To him and to his associate, Dr. Norman Brown, both employed full-time at the association's headquarters in Ottawa, falls the job of screening those letters and deciding the next course of action.

"We spend more than half our time responding to requests for miscellaneous advice rather than dealing with matters that are going to court," says Fisher. "I mean responding to such matters as the doctor who writes: 'The patient came in red-faced and gave me hell. But that's as far as it went. What do I do?' "

With that doctor, as with the one who writes that his patient believes he's been injured and demands recompense, the association asks the doctor if he's explained the situation fairly to the patient. If not, he's told: "Be accurate, be sympathetic—and be as brief as possible consistent with the two. Don't go into details. Don't theorize. Just tell him: This is what happened; you were kept informed."

Beyond that, the doctor is urged not to have any further discussion of the matter with the patient, except for the general statement that he did the best work he was capable of, the work was competent, and he will take no further responsibility in the matter. And that ends 75 percent of the cases.

If Fisher and Brown have any doubts about a case, however, they take it to the executive committee of the association at its weekly meetings. The committee, composed of private practitioners in the Ottawa area, also includes the association's general counsel. The doctor's comment on the case medically, and the lawyer offers his legal opinion. That disposes of most of the cases—usually never to be heard of again.

Enter the Attorney

But let's consider the case that goes beyond this stage. The patient hires an attorney, and the attorney writes the doctor, demanding recompense for the patient. Again the doctor contacts the association, and again he's told to respond in the same manner, to tell the attorney, in effect: "My care was competent and the best I was capable of. The patient was kept informed of developments. He knows the details of his case, and you can get further information from him. Yours truly."

Only about 60-odd cases out of the annual 450 or so proceed beyond that stage. The attorney files a writ, indicating that he intends to take the doctor to court. Now the association's general counsel steps in. Over the years, he's selected an attorney in each of Canada's 10 provinces to handle all the association's cases in that province. And through that experience, the provincial attorney becomes probably the most knowledgeable man in his area in medicolegal matters. He takes over the defense of the case at that point. About half the time, however, it's never pursued by the plaintiff beyond the writ stage.

"The plaintiff's attorney will argue up to the courthouse steps," says Fisher. "Then he'll suggest that the case will cost us, say, $4,000 or

$5,000 if we lose in court, and he's willing to settle for $1,000. We tell him: 'Mister, not only are you *not* going to get a settlement from us, but you're going to pay our costs to date. You've had the fun of trying to frighten the doctor. Now you can pay for that fun. Let's go into that courtroom and get the judge to dismiss it with costs.' " About 30 more cases usually melt away at that point.

Suppose a case hasn't melted away? The provincial attorney has investigated it and may advise the association that the doctor's action is defensible. He's told to defend it. Ore he may tell the association: "This is a 50-50 proposition. I'm not sure how a judge would regard this doctor's conduct." He's told to defend.

Few Settlements Offered

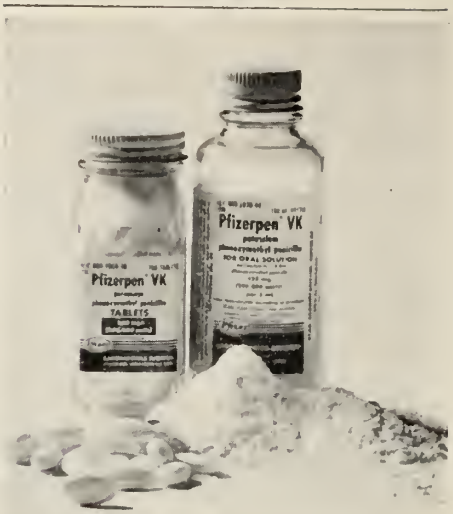
Only when the action seems indefensible—say an instrument left in the patient after surgery—will the Medical Protective Association settle. And then not always out of court. As Fisher puts it: "No matter what the incident, we never approach the plaintiff and offer a settlement. But we're not fools. If the patient had a forceps left in his belly, we'd be receptive to a settlement offer, provided he doesn't ask for more than we feel the incident was worth. If he does, we'll go to court, tell the judge we realize that the doctor was at fault, and ask him to determine a realistic award. We're not looking to gyp the patient, but we're surely not subsidizing him, either."

Let's consider a case where a forceps is left in a patient after an appendectomy. The following day, the patient complains of pain, the doctor X-rays, discovers the error, operates, removes the instrument, and the patient heals without complication. "If that case gets to court," Fisher says, "the judge is likely to tell the patient that although he's been inconvenienced, he's suffered no real harm. The recompense is likely to be pretty small, perhaps up to $2,500. If the instrument were left in there for a week and caused a partial intestinal obstruction that resulted in a complicated illness, naturally the award would be higher. We've paid as much as $7,500."

Judging by U.S. standards, the figures seem surprisingly low. But then Canada is not, as many Canadians are quick to point out, the 51st state. Its legal doctrines are different, its legal practices are different.

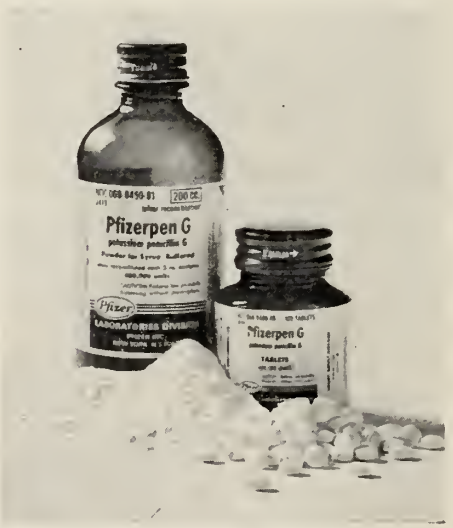
"Res ipsa loquitur plays no part in malpractice actions in Canada," says Fisher. "The onus is still on the patient to show where the doctor was wrong." As for the statute of limitations, it's one year in seven of Canada's 10 provinces, two

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in two provinces, and doesn't exist in one province. But where it does apply, it begins to run from "the time when the treatment of the matter complained of terminated." And that applies to minors as well as to adults.

Nor does the captain-of-the-ship doctrine, familiar in U.S. courts, apply in Canada. Among recent suits against doctors and hospitals where charges against the doctors were dropped was a case of mismatched blood and one in which the patient suffered burns from a hot water bottle in the operating room. "In both cases," says Fisher, "the doctor's order was correct, so the damage wasn't his fault. In the hot water bottle incident, the hospital suggested that it would pay 25 percent of a settlement and we could pay 75 percent. We made it quite clear that we wouldn't pay anything. In Canadian law, the physician has the right to delegate to an appropriately trained individual duties within that individual's training. And it has been repeatedly held by Canadian courts that nurses are trained to know the heat at which they may apply a hot water bottle. If they do it wrong, it's not the doctor's fault." Likewise, he notes, "the anesthesiologist is a legal individual in an operating room. If he makes an error, the surgeon is not held to be responsible."

That Contingency Fee

The matter of setting the attorney's fee is another major difference between the two systems. Unlike U.S. practice, it's considered unethical in most of Canada for an attorney to charge the contingency fee, one that's based on the outcome of the case and the size of the award. Only one province, Manitoba, allows such an arrangement, and lawyers there generally don't use it. The Canadian patient hires an attorney for a fee to be paid regardless of the outcome of the case. That factor alone could well dissuade patients from bringing suits on flimsy charges in hopes of nuisance settlements—especially since attorneys know well that the Medical Protection Association doesn't pay nuisance settlements.

Finally, all but two of the malpractice cases that have gone to court in the 70-year history of the association have been tried by a judge, not a jury. The plaintiff has the right to ask for a jury, but if the doctor-defendant can establish, in a sort of pretrial hearing, that the matter at hand is a scientific one that only a trained mind is likely to be able to judge competently, the court will rule against a jury trial.

"Our courts are fair, impartial, and *realistic*," says Fisher. "If the result to the patient was bad but we can demonstrate that the doctor's care was competent—not the care that could have been given by the best man in the district but ordinarily competent—we know that's the basis on which the court is going to judge the doctor. And more than once a court has finished a case by expressing sympathy with the patient for the result but dismissing the action because the result couldn't have been prevented by the doctor."

Even if there were malpractice, the patient wouldn't get an award that mirrors his total disability from his original condition. "To the best of the court's ability to judge it," Fisher says, "the award will mirror only the contribution of the alleged malpractice to the disability."

Fisher cites one case, for example, in which the court ruled that the patient really wasn't harmed by the medical incident but did deserve to have his court costs paid. The association had to reimburse him $45. In another case where a patient contended his eyeglasses were badly prescribed, he had to pay the association $6 to reimburse it for court costs when the case was dismissed.

Another interesting difference in the attitude of Canadian courts is reflected by a Nova Scotia case of several years ago. A hospitalized patient became confused, attempted to get out of bed, fell, and broke a leg. The doctor hadn't ordered sides on the bed and found himself in a suit that went all the way to court.

Both doctor and nurses said they hadn't felt the sides necessary because the patient had shown no previous periods of confusion. The court ruled in their favor. It said that it would prejudice the practice of medicine and decrease the grade of medical services available to the public if doctors or hospitals were penalized because of a rare mishap—one that couldn't have been expected even though it was known to be possible.

Though the frequency of actions against Canadian M.D.s hasn't increased, inflation is having an upward effect on awards and settlements, just as it is here. Ten years ago, the average payment for a foreign body left in a patient was $2,500. Now it's probably closer to $7,500.

What Price Preventive Medicine

Another factor that's familiar here is also expected to have an upward effect on payouts: preventive medicine. "In the old days," Fisher says, "no one operated unless a patient was going to die without the surgery. So malpractice shortened a patient's life by very little. Now a surgeon operates on a patient in his most productive years

(Continued on Page 323)

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Escherichia coli	11229	●	○	○
Escherichia coli	11698	●	○	○
Klebsiella pneumoniae	12833	●	○	○
Salmonella typhi	9993	●	○	○
Salmonella typhi	6539	●	○	○
Salmonella typhimurium	13311	●	○	○
Herellea sp.	11959	●	○	○
Pseudomonas aeruginosa	10145	○	○	○
Pseudomonas aeruginosa	7700	○	○	○
Pseudomonas aeruginosa	9027	○	○	○
Pseudomonas aeruginosa	14210	○	○	○
Proteus rettgeri	9250	○	○	○
Proteus morganii	9237	○	○	○

KEY: ZONE OF INHIBITION
●●● = 18.0 mm or larger
●● = 12.0 mm to 17.9 mm
● = Less than 11.9 mm
○ = No Inhibition

Test Method: The three antibacterial soaps were evaluated by means of the standard Protein Adsorption Test, conducted by a recognized independent laboratory, using A.T.C.C. organisms.

*The bacteria were those most frequently named in a nationwide survey of 334 hospitals.



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in order to restore health and prevent death at 45 instead of 65, say from a congenital heart condition. If that man is disabled through malpractice, we're going to have to support his family and pay for his care in a chronic treatment institution. We've had one such decision against us that has cost us $100,000 in damages."

Does the doctor who loses a $100,000 case jeopardize his membership in the association? "Any of us could be that man," says Fisher. "There would be no need for the association if that weren't true."

Fisher notes too that, over the years, no field of practice has proved to be more of a risk than any other field. "Today it might be the anesthesiologists," he says. "Two years from now the psychiatrists, and two years hence, the radiologists. We've found that a doctor isn't a risk because of his field. He's a risk because he's a doctor."

What can U.S. doctors learn from the Canadian experience? Certainly the enviable results that Canadian doctors have achieved offer some lessons that might be applied here. Consider what Canadian physicians have done: They've developed a uniform system for handling complaints anywhere in the nation from the first threat to the final demand for damages. They've developed expert defense counsel, and they've established a precedent for moving away from contingent legal fees. They've shown that taking a hard line with nuisance claims pays off and that doctors can find it better to deal with a judge than with a jury. And over-all, they've established that a whole medical profession can self-insure against malpractice.

The Canadian Experience: Some Lessons for U.S. Doctors

When physicians and medicolegal authorities reviewed prepublication copies of the preceding article, many of them saw lessons in the Canadian malpractice protective setup that could well serve physicians here. Some doctors looked wishfully to the north and said, as one put it, "I envy our Canadian cousins."

Seeing the two systems compared showed Dr. Mark Gorney of San Francisco a striking exaggeration of malpractice claims here. Gorney, who's chairman of the medicolegal survey committee of the American Society of Plastic and Reconstructive Surgeons, cites the great difference in malpractice insurance premium rates and the small distance in miles between Seattle and Vancouver, B.C. "Are we to surmise," he asks, "that under almost identical standards, U.S. doctors are so many times as bad? Or can it possibly be that our plaintiff's attorneys are to blame just a wee bit?"

The differences between the two systems have convinced Dr. Forrest P. White of Norfolk, Va., of the need for a middle ground. "Both malpractice-control systems, ours and the Canadians', seem out of balance," he says. "The Canadians have set up such a formidable system that the patient who truly suffers as a result of bad medical judgment must despair of receiving recompense. What we in the U.S. have is a brass-ring system that encourages patients and lawyers to grab for a big prize."

A doctor-lawyer, Cyril H. Wecht, director of the Pittsburgh Institute of Legal Medicine, sees a part of the Canadian system for U.S. physicians to copy: "The idea that a whole medical profession can self-insure against malpractice is a good one," he says. "The A.M.A. should try it."

Though these doctors and lawyers feel that the Canadian system could point the way to a better handling of the malpractice situation here, there's one element that medicolegal men stamp "not for import": the elimination of contingency fees. Says Wecht about the Canadian system: "Might not the lack of contingency fees keep patients who have substantial and reasonable claims from bringing suit?" And Eli Bernzweig, H.E.W. malpractice authority and executive director of President Nixon's new commission to study medical malpractice in the U.S., expects such fees to spread throughout Canada now that they're allowed in one province. "In 10 years all the provinces will be on this system," he says.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask o delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for a least 3 months should be instituted if the diagnosis of syphilis i suspected.

Safety for use in infants, children and pregnant women has no been established.

Precautions: The usual precautions should be observed wit atopic individuals. Clinical effectiveness should be monitored t detect evidence of development of resistance of *N. gonorrhoeae*

Adverse reactions: The following reactions were observe during the single-dose clinical trials: soreness at the injection site urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in norm human volunteers, the following were noted: a decrease in hemo

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High cure rate:* 96% of 571 males, 95% of 294 females
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No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

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A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

globin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramusculor injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
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Audio-Digest Adds Psychiatry to Tapes

The Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) recently announced that it will add psychiatry to its group of subscription recordings, possibly beginning late this summer.

At present more than 100,000 tapes are mailed to all parts of the world each month. For 20 years the service has been in operation. Specialty subjects covered are anesthesiology, family practice, internal medicine, obstetrics-gynecology, ophthalmology, otorhinolaryngology, pediatrics, and surgery.

Persons interested in the psychiatry digests should write Mr. Claron L. Oakley, Audio-Digest Foundation, 1930 Wilshire Blvd., Los Angeles, Calif. 90057.

Study Atherosclerosis in Children

A University of Cincinnati Medical Center program of testing newborn infants to determine need for early prevention of atherosclerosis will soon be extended to older children and eventually to high schoolers.

The testing is now available to newborns at General Hospital (major hospital in UC's Medical Center) and at Bethesda Hospital. Its expansion has been made possible through a three-year grant totalling $219,448 from the National Heart and Lung Institute, supporting the program from January 1, 1972, through December 31, 1974.

The grant is to the UC Department of Internal Medicine directed by Dr. Richard W. Vilter, professor of medicine.

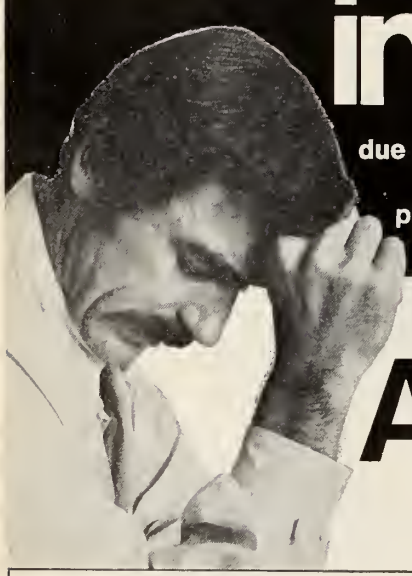
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T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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REFER TO PDR

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiore disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasio cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Tes terone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headac dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive h failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected p to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, pati receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontir as soon as hypercalcemia is detected.

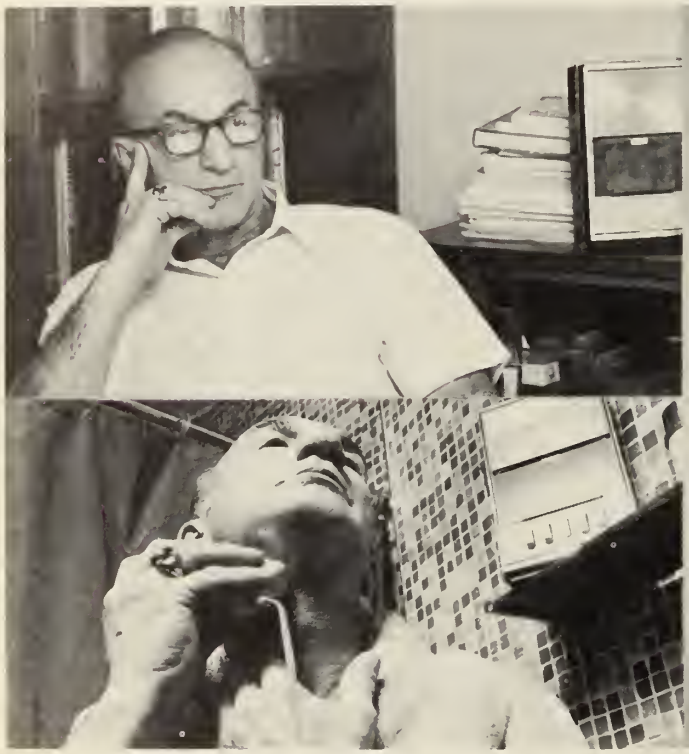
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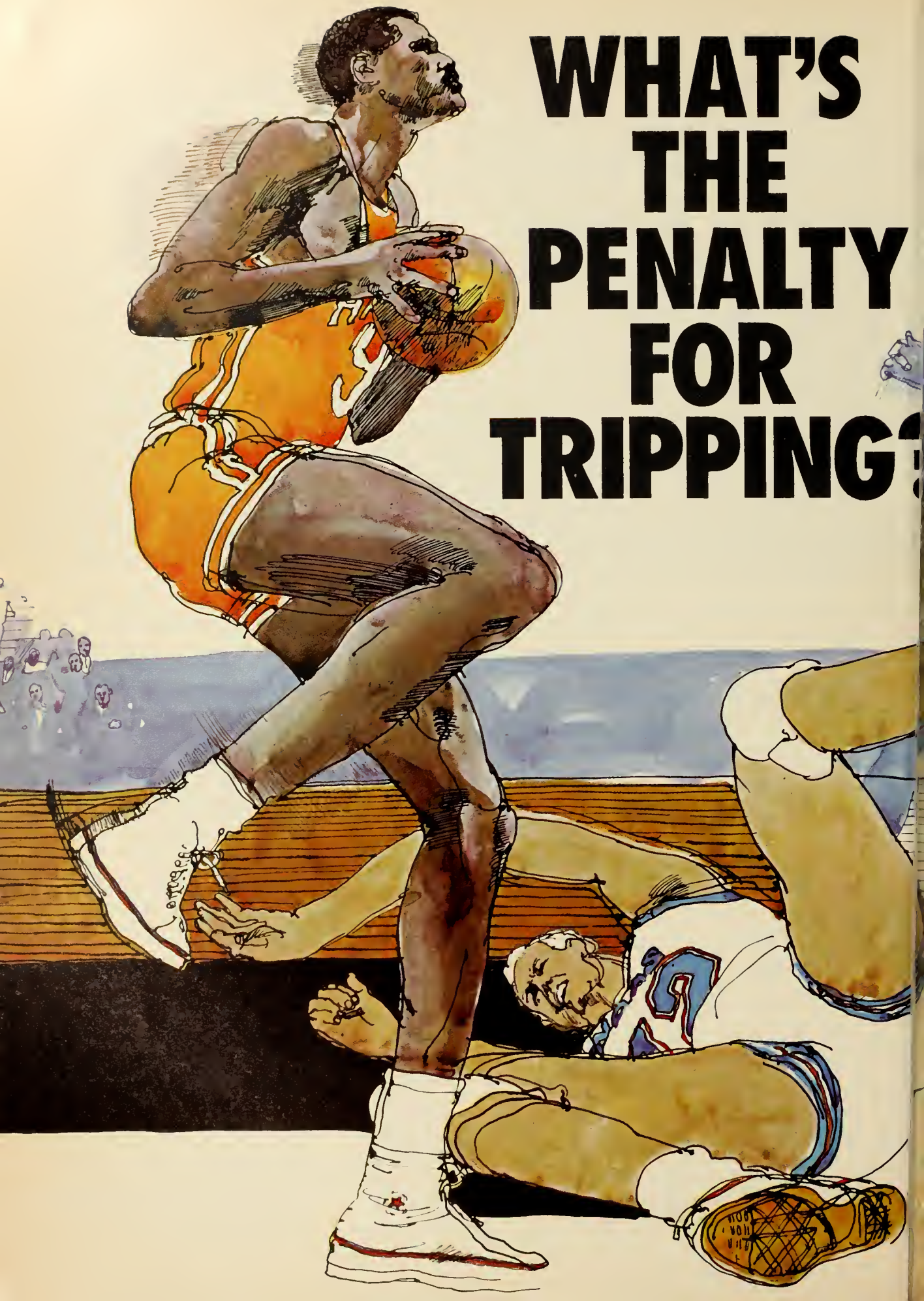
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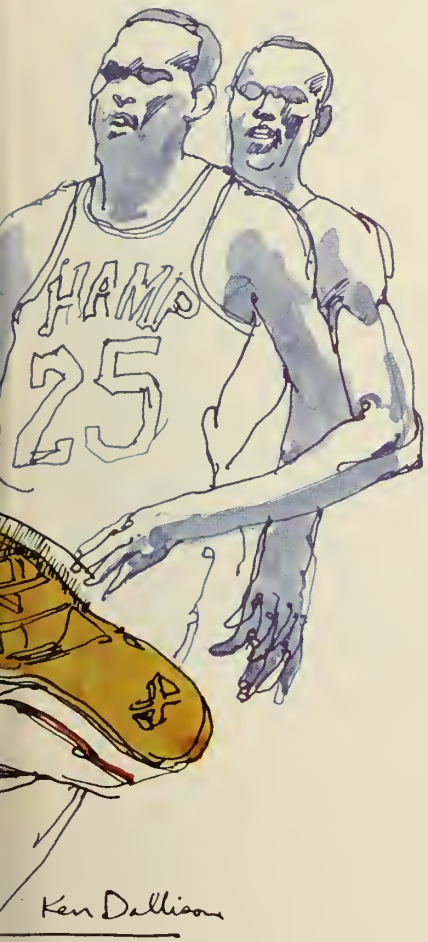
Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Physician Honored with Governor's Award



Governor John J. Gilligan is shown above presenting the 1971 Ohio Governor's Award to Dr. Frederick C. Robbins, Dean of the Case Western Reserve University School of Medicine for, in the Governor's words, "excellence of achievement and contributions to improving the quality of life for all Ohioans."

The individual citation reads as follows: "The 1971 Ohio Governor's Award is presented to Dr. Frederick Chapman Robbins on February 11, 1972 in recognition of excellence of achievement in the field of medicine and for commitment to easing the mental and physical suffering of all humans with special sensitivity for diseases afflicting children."

Dr. Robbins came to Case Western Reserve University in the early 1950's as a member of the pediatrics faculty. He was named dean of the School of Medicine in 1966. In 1954 he was awarded the Nobel Prize in physiology and medicine, together with two former colleagues, for research at Harvard. The team, working in 1948 and 1949 at Harvard, developed a method of growing polio virus in non-nervous tissue in test tubes, a giant step in the development of polio vaccine.

The American Rheumatism Association Section of The Arthritis Foundation is offering a Review Session in Rheumatology mainly for physicians wishing to take the subspecialty examinations for certification in Rheumatology being given for the first time this year by the American Board of Internal Medicine on October 17. The Review Session will take place on June 10 at the Fairmont Hotel in Dallas, Texas in conjunction with the annual meeting of the American Rheumatism Association.

When you prescribed Orinase®

(tolbutamide, Upjohn)

14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessar for optimal control with insulin are also necessary with Orinase The patient on Orinase must be fully instructed: about th nature of his disease; how to prevent and detect complication how to control his condition; not to neglect dietary restriction develop a careless attitude or disregard instructions relative t body weight, exercise, personal hygiene, and avoidance of in fection; how to recognize and counteract impending hypogl cemia; how and when to test for glycosuria and ketonuria; ho to use insulin; and to report to the physician immediately if h does not feel as well as usual.

Caution, very close observation, and careful adjustment dose are necessary when: insulin is withdrawn during the tri period in order to avoid ketosis, acidosis, and coma; thiazic diuretics are administered which may result in aggravation diabetic state and increased tolbutamide requirement, temp rary loss of control, or even secondary failure; treating patien with impaired hepatic and/or renal function and debilitated, ma nourished, or semistarved patients in order to avoid severe hyp glycemia which may require corrective therapy over sever days; and treating patients with severe trauma, infection, or su gical procedures where temporary return to insulin or additi of insulin may be necessary. Response to tolbutamide is dimi ished in patients receiving therapy with beta blocking agen

As some diabetics are not suitable candidates, it is essent that the physician familiarize himself with the indications, lim of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, a during the initial test period should communicate with the phy

Today you have your own.

If you're around 40 or 45, you've probably had quite a bit of clinical experience with Orinase.

Maybe as much as 14 years.

And that means you know quite a bit about it.

On the one hand, you know that diet and weight control are the initial and essential foundations for the management of adult-onset, non-ketotic diabetes. When these measures prove satisfactory, no additional therapy is indicated. On the other hand, you know that if these measures fail the addition of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase®

0.5 g. tablets

(tolbutamide, Upjohn)

cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

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Continuing Education Opportunities for Physicians in Ohio

April

Sixth Postgraduate Symposium on Diabetes—Presented by Diabetes Association of the Cincinnati Area and Department of Continuing Education, University of Cincinnati College of Medicine at the Carrousel Inn, 8001 Reading Road, Cincinnati, April 12, 9:30 a.m. to 5:00 p.m. Contact Diabetes Association of the Cincinnati Area, 2400 Reading Road, Cincinnati 45202; (513) 721-2905.

Postgraduate Program in Diabetes Mellitus—Presented by the Greater Akron Area Diabetes Association, April 12 at the Akron General Medical Center, 400 Wabash Ave., Akron. Contact Greater Akron Area Diabetes Association, 430 Grant St., Akron 44311.

Pediatric Clinic Day—At Children's Hospital, Columbus, Wednesday, April 12, with registration open at 8:00 a.m.; sponsored by the OSU College of Medicine, Department of Pediatrics and Children's Hospital; contact Center for Continuing Medical Education at OSU—(614) 422-4985.

Depression in Medical Practice (Workshop)—Sponsored by Ohio State University College of Medicine, Department of Psychiatry, at Stouffer's University Inn, 3025 Olentangy River Road, Columbus; April 13 (evening) and 14 (morning and afternoon); contact Center for Continuing Medical Education, A-352 Starling Loving Hall, 320 W. Tenth Ave., Columbus 43210.

Internal Medicine (Visiting Professor Program) — Akron City Hospital, 525 East Market Street, Akron, April 13-14; Dr. William Keith C. Morgan, West Virginia University School of Medicine.

Depression in Medical Practice—Ohio State University Department of Psychiatry, April 13-14, at Stouffer's University Inn, 3025 Olentangy River Road, Columbus; contact the Center for Continuing Medical Education at the OSU Medical Center.

> Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Term Management of Acute Respiratory Failure — Cosponsored by the American College of Chest Physicians and the Cleveland Clinic, at the clinic; April 13-15.

What the GP Should Know About Anesthesia — St. Elizabeth Hospital, Youngstown; April 14, 8:00-9:00 a.m.; Dr. R. Richards.

Lederle Symposium on "Being a Physician in Our Time" — Ohio Academy of Family Physicians and Ohio State University College of Medicine, at the Sheraton-Columbus Motor Hotel, downtown Columbus, April 16.

A Day of Therapeutics — Akron City Hospital, 525 East Market Street, Akron; American Society for Clinical Pharmacology and Therapeutics, April 19.

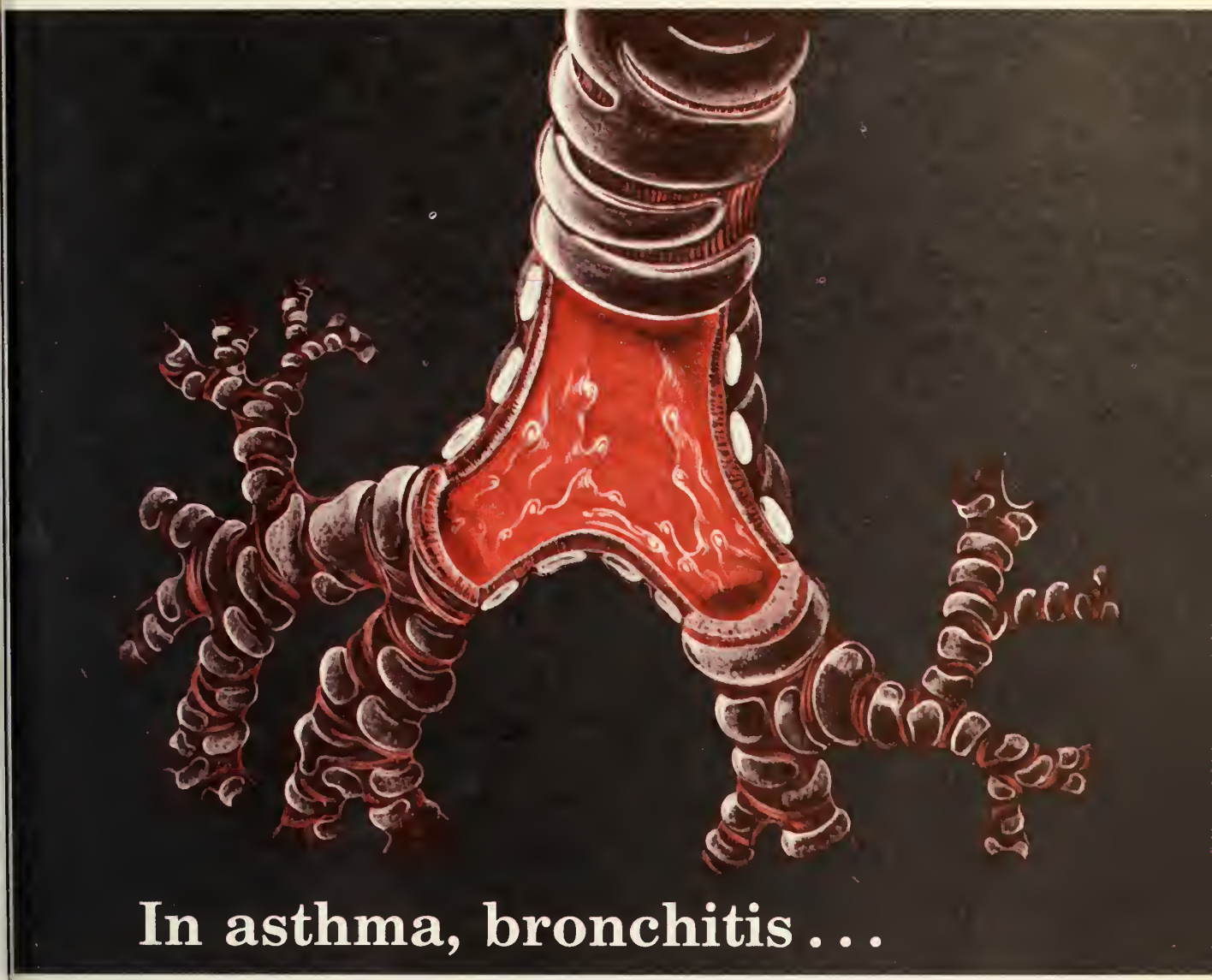
Advances in Orthopaedic Surgery — Cleveland Clinic Educational Foundation, April 19-20.

The Hospital-Wide Coronary Care System — Sponsored by the American College of Cardiology, at Good Samaritan Hospital, Dayton, April 19-20.

Estrogens and Their Abuses — St. Elizabeth Hospital, Youngstown, April 21, 8:00-9:00 a.m.; Dr. L. Alexander.

(Continued on Page 341)

MOVE-OUT STICKY MUCUS...



In asthma, bronchitis...

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

"For the viscid sputum, potassium iodide (... preferable as enteric coated tablets) may be best."[2]

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Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

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"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

". . . there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy

ARTERIDSCLERDSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous memorane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *ij* tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

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The girth control pill



Tepanil® Ten-tab®

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(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets. One 75 mg tablet daily, swallowed whole, in midmorning (10 a.m.). TEPANIL. One 25 mg tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

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Prescribing Informotion — Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** Quinamm is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reoctions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosoge:** One tablet upan retiring. Where necessary, dasage may be increased to one tablet fallawing the evening meal and one tablet upon retiring. **Supplied:** Battles of 100 and 500 tablets.

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Quinamm

(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps.

Educational Opportunities in Ohio — *Continued*

New Antibiotics — Youngstown Hospital Association, South Unit; April 24; 4:00 p.m.; Drs. G. A. Butcher and S. A. Khuddus.

New Concepts and Practices in Diseases of the Colon and Rectum — Cleveland Clinic Educational Foundation, April 26-27.

The Low Back Problem; Proper Examination Explained — St. Elizabeth Hospital, Youngstown; April 28, 8:00-9:00 a.m.; Dr. J. J. Sofranec.

Introductory Course in Nuclear Medicine for Physicians — Dates on request to Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

May

Seventh Annual Dickson, Duncan, Rainbow, Reich Orthopaedic Lectureships — At St. Luke's Hospital, 2065 Adelbert Road, Cleveland; May 1-2; guest lecturers, Drs. R. L. Cruess, R. B. Duthie, W. W. Lovell, and H. E. Pedersen; program sponsored by the Cleveland Orthopaedic Club in conjunction with Orthopaedic Departments of Cleveland Clinic, Mt. Sinai, St. Luke's and University Hospitals; for reservations contact Dr. S. Nahigian, 3461 Warrensville Center Road, Cleveland 44122.

Arteriosclerosis and the Anesthesiologist — Cleveland Clinic Educational Foundation, May 3-4.

Recent Advances in Abdominal Surgery — At Shriners Burns Institute, Cincinnati, May 3-4; Dr. William A. Altemeier, director; contact Office of CONMED, Eden and Bethesda Avenues, Cincinnati 45219.

Most Common Endocrine Disturbances, Exclusive of Diabetes and Thyroid Disease — St. Elizabeth Hospital, Youngstown; May 5, 8:00-9:00 a.m.; Dr. D. Corredor.

Current Virus Infections on the Youngstown Scene — Youngstown Hospital Association, South Unit, May 8, 4:00 p.m.; Drs. R. Tamburro and N. A. Jaffer.

Ectopic Hormone-Producing Tumor Syndromes — Trumbull Memorial Hospital, Warren, May 9, 12:00 noon to 1:00 p.m.; speaker, Dr. Jerome Kowal, Case Western Reserve University School of Medicine.

Neonatology — Educational forum of the Cleveland Society of Obstetricians and Gynecologists, Wednesday, May 10, 3:00 p.m. in the Bunts Auditorium, Cleveland Clinic; speaker: Joseph Butterfield, M.D.; followed by dinner and evening program. Contact, Kathryn E. Hoffman, M.D., 806 Rose Bldg., Cleveland 44115.

Renal Hypertension Clinic — RMP, University of Pittsburgh — St. Elizabeth Hospital, Youngstown; May 12, 8:00-9:00 a.m.

Family Relations Workshop—Ohio Academy of Family Physicians Continuing Education in Psychiatry project, Toledo Holiday Inn, May 12-14.

Ohio Radiological Society, Scientific Program—Cincinnati, May 12-14 (immediately following OSMA Annual Meeting). Contact Dr. H. Horwitz or Dr. H. Schneider, Department of Radiology, Cincinnati General Hospital, Burnet Ave., Cincinnati 45229.

Learning Disabilities in Children — Annual Meeting of the Ohio Chapter, American Academy of Pediatrics, May 13-14 at Atwood Lake Lodge. Contact Charles Q. McClelland, M.D., Chairman, 2101 Adelbert Road, Cleveland 44106.

Flexible Viewing and Photography of the Stomach and Duodenum — Youngstown Hospital Association, South Unit, May 15, 4:00 p.m.; Drs. D. B. Brown and S. S. Guleria.

Anorectal Problems for the Generalist — St. Elizabeth Hospital, Youngstown; May 19; 8:00-9:00 a.m.; Dr. J. Herald.

Cytochemistry Applied to Hematology — Co-sponsored by the American Society of Clinical Pathologists and the Cleveland Clinic Educational Foundation, at the clinic; May 19-20.

Management of Coronary Occlusion — St. Elizabeth Hospital, Youngstown; May 26, 8:00-9:00 a.m.; Dr. A. Whittaker.

Hepatitis — Subacute Hepatitis, Chronic Active Hepatitis, Needle Hepatitis — Youngstown Hospital Association, South Unit, May 29; Drs. G. A. Butcher and R. S. Arnott.

Fourteenth Annual Refresher Course in Diagnostic Roentgenology — Department of Radiology, University of Cincinnati College of Medicine; Dr. Benjamin Felson, director; May 30-June 3; includes nuclear medicine, radiation physics and radiation therapy; contact Dr. Harold B. Spitz, Department of Radiology, Cincinnati General Hospital, Cincinnati 45229.

(Continued on Page 343)

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Educational Opportunities in Ohio — *Continued*

A Practical Approach to Complex Arrhythmias for Cardiovascular Nurse and Physician— Sponsored by the American Heart Association, Eastern Ohio Chapter, at the Ramada Inn, I-80 at Belmont Avenue, Youngstown, May 31-June 1; Contact American Heart Association, Eastern Ohio Chapter, 2516 Market St., Youngstown 44507.

June

Stroke and Rehabilitation — St. Elizabeth Hospital, Youngstown; June 2, 8:00-9:00 a.m.; Drs. R. Gilliland and A. Riberi.

Granulomatous and Nongranulomatous Colitis — Youngstown Hospital Association, South Unit, June 5; Drs. D. B. Brown and Y. P. Sheth.

Symposium on Microneurosurgery — Departments of Neurosurgery, Good Samaritan and Christ Hospitals, Cincinnati, June 8-10; distinguished guest and local faculty; Contact Dr. John M. Tew, Jr., 506 Oak Strect, Cincinnati 45219.

Anxiety Reactions and Their Management — St. Elizabeth Hospital, Youngstown; June 9, 8:00-9:00 a.m.; Dr. F. Gelbman.

Modern Concepts in Clinical Cardiology — An American College of Physicians postgraduate course; University of Cincinnati College of Medicine, June 12-16; director, Noble O. Fowler, M.D.; codirector, Robert J. Adolph, M.D.

Management of Hypertension — St. Elizabeth Hospital, Youngstown; June 16, 8:00-9:00 a.m.; Dr. W. Bunn.

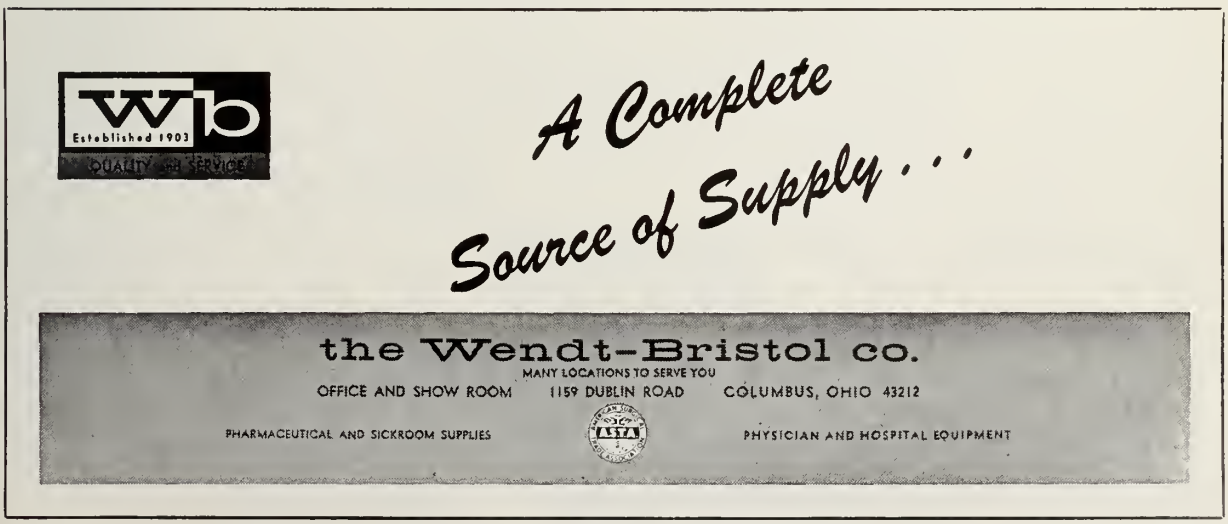
Drug Induced Thrombocytopenia and Hemolytic Anemia — Youngstown Hospital Association, South Unit, June 19; Drs. L. M. Pass and N. A. Pappas.

Worms and Man — St. Elizabeth Hospital, Youngstown, June 23, 8:00-9:00 a.m.; Drs. G. Canatsey and P. Van Zandt.

August

Fifth Postgraduate Institute for Physicians on Sports Medicine — Sponsored by OSMA, Ohio High School Athletic Association, and the OSU College of Medicine, August 2-3 at the Center for Tomorrow, 2400 Olentangy River Road, Columbus. Contact Center for Continuing Medical Education at Ohio State; registration fee, $30.

Annual Scientific Assembly, Ohio Academy of Family Physicians—Sheraton-Columbus Hotel, downtown Columbus, August 8-10.




In the glaucoma patient
on cerebral or peripheral
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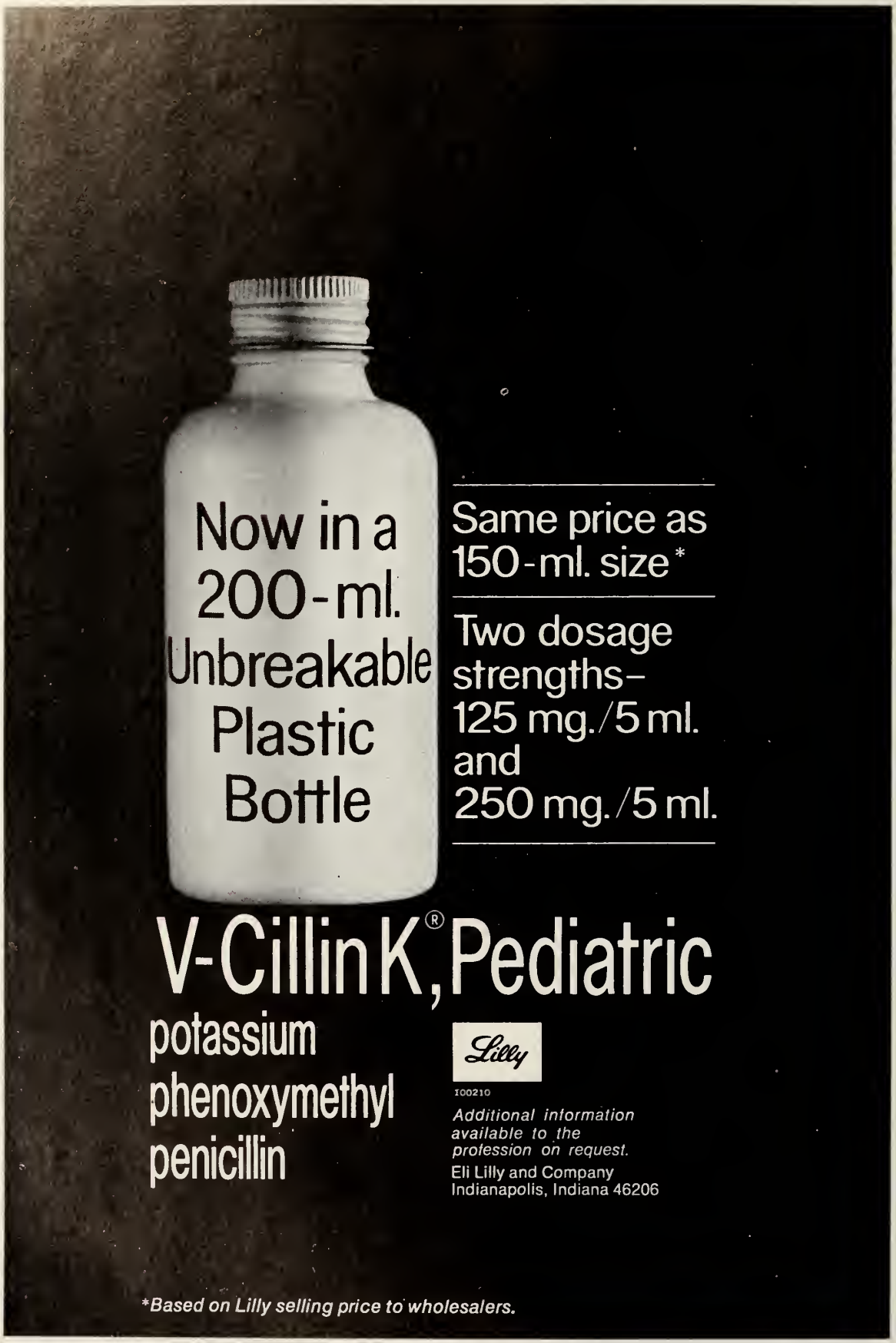
- no reported increase of intraocular pressure.
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, diabetes, peptic ulcer or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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Clinical & Scientific Features



VOLUME 68 APRIL 1972 NUMBER 4

Irradiation-Induced Thyroid Neoplasms

Case Reports and Review

KENNETH A. FRANKEL, M.D.; NEIL R. THOMFORD, M.D.; AND WILLIAM J. HOLADAY, M.D.

THE ASSOCIATION of external irradiation of the neck with the subsequent development of thyroid carcinoma has been documented by several authors.[1-5] Far less attention has been given to the association of x-irradiation with the development of thyroid adenomas. The propensity to develop both benign and malignant neoplasms of the thyroid after irradiation of the neck is emphasized by the following case reports.

Case 1.—A 26-year-old woman was admitted to The Ohio State University Hospitals for evaluation of multiple thyroid nodules discovered during a routine physical examination. Two years before admission she had had a partial right thyroid lobectomy for a solitary fetal adenoma of the thyroid (Fig. 1). During the interim she remained asymptomatic. Her past medical history included external radiation to the head and neck at age 4 years for "swollen lymph glands." The details of the irradiation therapy were not available. Additional history included appendectomy at 9 years of age and tonsillectomy at 16 years.

On physical examination, abnormal findings were confined to the neck where several firm, nontender 1- to 1.5-cm nodules were palpable in the left lobe of the thyroid. A solitary 1-cm nodule was palpable in the residual portion of the right lobe. Laboratory data including results of determinations of red blood cell uptake of T_3, protein bound iodine, and uptake of ^{131}I by the thyroid were all within the limits of normal. A scintigram of the thyroid showed two areas of decreased uptake of ^{131}I in the left lobe suggesting the presence of nodules. Roentgenograms of the chest did not show any abnormalities. Operation was advised but the patient declined and is currently being followed by her physician.

Case 2.—A 20-year-old man was admitted to The Ohio State University Hospitals for evaluation of enlargement of his thyroid gland. At age 18 years, a precollege physical examination disclosed thyroid enlargement. He was treated with desiccated thyroid and remained asymptomatic. His past medical history included "scrofula" at age 16 months documented by histologic study of a lymph node. In addition to medication, he was treated with irradiation therapy to the right side of his neck for a period of three to four weeks. The details of the irradiation therapy were not available.

On physical examination, the thyroid was enlarged to two to three times normal size with the right lobe being more prominent than the left. The right side of the mandible was smaller than the left side and the muscles of the right neck were underdeveloped. The skin of the right neck was thin and the telangiectasia alterations in pigmentation were typical of those induced by irradiation therapy. Laboratory data including results of determinations of red blood cell uptake of T_3, protein bound iodine, and uptake of ^{131}I by the thyroid were all within the limits of normal. A scintigram of the thyroid showed a nonhomogenous pattern of radioactivity throughout the gland with a "cold" nodule in the inferior pole of the right lateral lobe. The patient underwent total thyroidectomy and the thyroid gland contained multiple micro- and macrofollicular adenomas.

Case 3.—A 36-year-old man was admitted to The Ohio State University Hospitals for evaluation of a "tumor of the thyroid." Two years prior to admission the patient noted a swelling in the left side of his neck. During the next two years the lesion slowly increased

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Thirty days before admission it was excised. Histologic study showed metastatic papillary adenocarcinoma in a lymph node. His past medical history included a course of irradiation therapy at age 16 years because of excessive lymphoid tissue in the nasopharynx. Details of the treatment were not available.

On physical examination, there were no palpable abnormalities of the neck. The results of the routine blood and urine tests were all within the limits of normal. Roentgenograms of the chest did not show any abnormalities. Removal of the left lateral lobe, isthmus, and the major portion of the right lateral lobe of the thyroid was combined with a left radical neck dissection. An occult papillary adenocarcinoma was present in the left lobe of the thyroid. Forty-three cervical lymph nodes were examined by light microscopy and none contained metastasis.

Case 4.—A 14-year-old girl was initially admitted to The Ohio State University Hospitals because of interstitial pneumonitis. She rapidly recovered from the pneumonia but a review of body systems disclosed progressive enlargement of the thyroid gland of six-months' duration. Significant past medical history included removal of a neuroblastoma from the thorax at age 5 months. After operation she received external irradiation to the mediastinum in a dose of 3,000 rads during a period of 90 days. Physical findings included thyroid enlargement and a Horner's syndrome on the left side. She was dismissed from the hospital and readmitted five weeks later for evaluation of the enlargement of her thyroid gland.

On physical examination, the thyroid gland was described as multinodular and was estimated to be three times the expected normal size. Laboratory data including results of determinations of red blood cell uptake of T_3, protein bound iodine, and uptake of ^{131}I by the thyroid gland were all within the limits of normal. A scintiscan was interpreted as showing a multinodular goiter with a single "cold" nodule in the upper portion of the left lateral lobe. A total thyroidectomy was done. Histologic study of the thyroid showed multiple adenomas (Fig. 2).

Discussion of Thyroid Cancer with Irradiation

During the early part of this century, it was common practice to prescribe irradiation therapy for a host of benign lesions of the head and neck. By the late 1940's, however, reports suggested an association between irradiation of the neck and the subsequent development of thyroid carcinoma.[1,2] Quimby and Werner[1] were the first to discuss this relationship in regard to adult patients treated for hyperthyroidism with roentgen therapy. Then, in 1950, Duffy and Fitzgerald[2] reported the development of thyroid cancer in 10 of 28 children who had had irradiation to the head and neck. Subsequent reports of children with cancer of the thyroid disclosed that all patients in the series reported by Clark[3] and 80 percent of the patients reported by Winship and Rosvoll[4] had a history of external irradiation of the head and neck. Thus the relationship between external irradiation to the head and neck and the subsequent development of thyroid carcinoma was established. Information has since accumulated to substantiate a similar relationship between irradiation to the head and neck and the subsequent development of benign nodules of the thyroid gland. In a group of infants each of whom was exposed to an equal amount of external irradiation, the incidence of thyroid nodules was 30 percent.[5] Additional evidence of this association was recorded by Hempelmann[6] when he reported a substantial increase in the incidence of thyroid adenomas in persons receiving external radiation to the thyroid.

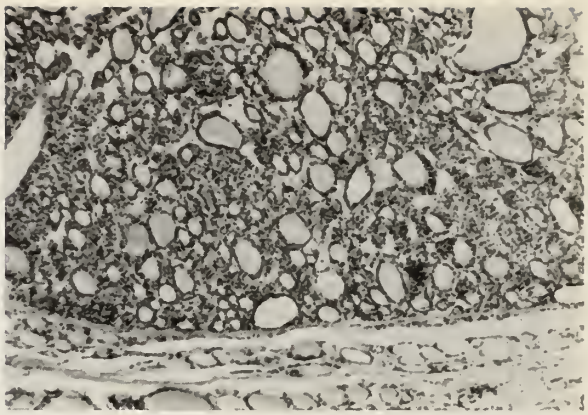


Fig. 1. Fetal adenoma present in thyroid gland of patient who received external irradiation to the head and neck 20 years prior to operation.

The dose of irradiation necessary for the development of thyroid neoplasms is not known, but Hemplemann's studies[7] of three groups of children exposed to variable doses of radiation suggest a linear relationship between the dose of radiation and the incidence of nodules of the thyroid. At radiation levels as low as 20 rads, the incidence of thyroid tumors requiring operations was greater than in a comparable non-irradiated population. Beach and Dolphin[8] found that 1 percent of the patients who had received from 200 to 300 rads to the head and neck developed a thyroid carcinoma. The incidence of thyroid carcinoma was 1.7 percent for doses between 350 to 500 rads, and 1.6 percent for doses between 500 to 900 rads.

Two theories have been proposed to explain radiation-induced neoplasia of the thyroid. The first and most familiar is that irradiation induces

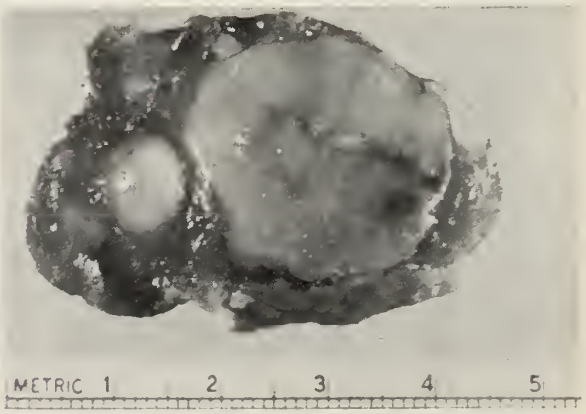


Fig. 2. Multiple adenomas in thyroid gland of 12-year-old girl who received 3,000 rads to the thorax and neck during period of 90 days, at age 5 months.

mutations in the thyroid, and the subsequent daughter cells, not governed by normal cell control, develop into a neoplasm. The proclivity for this mutation seems to be dose-related with the highest incidence of malignancy in dose ranges of 200 to 500 rads.[8] The second theory suggests that thyroid neoplasia results from a combination of the direct effect of radiation and an increased production of thyroid stimulating hormone (TSH).[9] It is postulated that external irradiation causes mild thyroid hypofunction, and the resulting excessive release of thyroid stimulating hormone (TSH) plays an important role in the development of hyperplasia, adenomas, or carcinoma of the thyroid gland. The possible role of TSH is supported by the fact that the incidence of radiation-induced thyroid carcinoma in laboratory animals is increased by pretreatment with antithyroid drugs.[10] If correct, this theory helps to explain the fact that children with actively proliferating thyroid tissue and elevated levels of TSH are most susceptible to radiation-induced thyroid neoplasia. It is probable that both the direct effect of irradiation and the increased production of TSH are important in the pathogenesis of thyroid neoplasms.

In treating patients with tumors of the thyroid, the physician may well ask how his treatment is modified, if at all, when there is a history of previous irradiation to the head and neck. The management of the patient with a solitary nodule of the thyroid gland is not altered by a history of radiation to the head and neck. The incidence of carcinoma in solitary nodules of the thyroid justifies operation regardless of whether or not the patient has a history of irradiation of the head and neck. Operation is especially important for those patients less than 20 years of age since in this age group a solitary nodule of the thyroid is malignant in 40 to 50 percent of patients.[11] When the patient has multiple nodules of the thyroid as determined by physical examination, a history of irradiation to the head and neck becomes a more important factor in deciding appropriate management. Many patients with multinodular goiters may be managed without an operation; however, because the incidence of thyroid carcinoma in a multinodular goiter is increased when there is a history of irradiation to the area of the thyroid, these patients should undergo operation. Therefore all patients with an abnormality of the thyroid gland, be it a solitary nodule or multiple nodules, who have a history of irradiation to the head and neck should be advised to have an operation.

Summary

External irradiation of the neck appears capable of inducing the development of thyroid neoplasia. Radiation-induced neoplasms of the thyroid include both adenomas and carcinomas. Neoplasia is thought to be the result of a direct effect of irradiation on thyroid epithelium. An indirect effect of apparent importance, is increased production of TSH secondary to the hypothyroidism caused by the irradiation. Patients with abnormalities of the thyroid who have a history of irradiation to the head, or neck should be advised to undergo an operation.

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A Critical Analysis of In Vitro Thyroid Function Tests

Phillip B. Teitlebaum

THIS ARTICLE considers the various in vitro thyroid function tests available in clinical practice and compares their diagnostic efficacy. The most readily available tests, the ones discussed here in some detail, are the protein-bound iodine (PBI) test, the T_4 tests, the T_3 uptake tests, and the free throxine indices.

The goal of all in vitro thyroid function tests is to reflect the effective blood levels of the thyroid hormones T_4 (thyroxine, L-3, 5, 3′,5′-tetraiodothyronine) and T_3 (liothyronine, L-3, 3′,5′-triiodothyronine). These hormones produce the clinically defined states of hyperthyroidism when overabundant, and hypothyroidism when insufficient. The hormone T_4 (thyroxine) is measured in the PBI and T_4 tests and is present in total serum concentration of about 5 to 12 μg per 100 ml. Over 99.5 percent of the total T_4 is bound to the serum proteins TBG (thyroxine-binding globulin) and, to a lesser extent, TBPA (thyroxine-binding prealbumin). TBG should not be confused with the protein thyroglobulin, which normally is found only in the thyroid gland and is involved in thyroid hormone synthesis and storage. Usually about one third of TBG's binding sites are occupied by T_4 molecules. The unoccupied, or unbound, binding sites provide the basis for the T_3 uptake tests. The protein-bound T_4 is physiologically inactive, but it exists in relative equilibrium with circulating free thyroxine (FT_4). Changes in the TBG level cause variations in the total T_4 concentration that do not reflect the concentration of active free hormone, FT_4.[1-6] The hormone T_3 (triiodothyronine) is bound much less firmly than T_4 to these proteins. Also, T_3 is four times as potent per mole in terms of thyrometric activity as T_4. Therefore, the very low serum concentration of T_3 (1/15 to 1/20 that of T_4) belies its importance.

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The PBI

The protein-bound iodine test[7-11] assays all iodine adsorbed to serum protein. It assumes that most iodine measured is thyroid hormone (T_4). The analytic technic is a colorometric one and is based on iodine's ability to catalyze the reaction $2Ce^{4+} + As^{3+} \rightarrow 2Ce^{3+} + As^{5+}$.

Advantages: The test uses only 0.1 ml of serum and is capable of accurately measuring microgram quantities of iodine.

Disadvantages: The test is not a reliable measurement of serum T_4. Its result is elevated by an increase in any organic variety of serum iodine, such as that found with thyroiditis, iodine-containing contrast media, or orally ingested Lugol's or other iodine-containing solutions.[12] Values are elevated when TBG is increased (eg,

with estrogen therapy, pregnancy, birth control pills) and are lowered by conditions decreasing TBG (eg, androgen therapy, nephrotic syndrome). Values are also lowered by prolonged therapy with certain drugs (eg, aspirin, diphenylhydantoin) which compete with T_4 for binding sites on the TBG molecule and displace some of the hormone from the protein. This decrease in protein-bound T_4 is reflected by a drop in the PBI. Finally, the test result can be falsely lowered by heavy metal contamination of the reagents.

The T_4 Tests

The two commonly found variants of the test are the "T_4 by column" and the Murphy-Pattee T_4 test. Both purport to measure total serum T_4. In the T_4 by column test, serum is poured through an anion exchange resin column. The T_4 binds to the resin and other serum components, including contaminating iodine compounds, wash through. The T_4 is then washed from the column, ashed, and the iodine remaining is assayed by the same technic used for the PBI.[3]

Advantages: The test result is more nearly representative of the amount of T_4 present than is the PBI.

Disadvantages: The test is difficult to perform. As a result, technical error is just as great a problem as with the PBI. Also, large quantities of iodine in the serum may still cause contamination of the test.

The Murphy-Pattee T_4 test[13,14] uses the principle of competitive protein binding analysis and employs radioactive thyroxine (T_4*). An initial alcohol extraction separates most of the protein present from its adsorbed T_4. This T_4-containing extract is then added to a tube containing a small amount of TBG bound to T_4*. As the T_4 extract is added, the radioactive thyroxine (T_4*) is displaced from the TBG and is subsequently adsorbed to an anion exchange resin. Counting the radioactivity in either the resin or the solution (after removal of the resin) yields a value which is proportional to the quantity of total serum thyroxine originally present. The reactions are as follows:

(1) T_4 (extract) + TBG-T_4 = TBG-T_4 + T_4*

(2) Resin + T_4* = resin-T_4*

Advantages: The relative technical ease of the test as compared with T_4 by column, the nearly total freedom from the influence of iodine contamination, and the test's reproducibility are its main advantageous features.

Disadvantages: A major problem is the spurious alteration of the total T_4 concentration with drug therapy or disease states not directly related to thyroid function. As already discussed under the PBI test, medications that increase TBG will increase total T_4, medications that decrease TBG will decrease total T_4, and medications that compete with T_4 for TBG binding sites will decrease total T_4. Since most of the drugs causing such difficulties tend to elevate the total T_4, it is justifiable to consider a low T_4 value as usually indicative of hypothyroidism. A high value, on the other hand, should be considered less reliable.

The T_3 Tests

These tests do *not* measure serum T_3 (triiodothyronine). They are instead a measure of unbound TBG binding sites, using radioactive triiodothyronine (T_3*) as a test reagent. The original Hamolsky red cell T_3 uptake test,[15] a veritable technician's nightmare, has been superseded by the T_3 resin uptake tests.[16] The test is performed by adding T_3* to the patient's serum, thereby permitting some of the T_3* to bind to the serum TBG's unbound binding sites. An anion exchange resin is used to remove the unbound T_3*. Counting either the resin or the serum radioactivity provides an index of the number of free binding sites of TBG. The reactions are:

(1) TBG + T_3* = TBG-T_3*

(2) T_3* + resin = T_3*-resin

The T_3 uptake value is roughly inversely proportional to the concentration of unbound TBG binding sites.

Advantages: The test is easy to perform and provides a rough guide to the serum concentration of unbound TBG binding sites. The test result is not affected by the presence of nonhormonal iodine.

Disadvantages: Anything that decreases the number of unbound binding sites elevates the T_3 uptake. Hyperthyroidism does this by tying up binding sites with higher-than-normal numbers of T_4 molecules; but large quantities of aspirin, diphenylhydantoin, or other drugs that bind to TBG exert the same effect. Also, if the total TBG concentration is lowered, there are fewer TBG binding sites. Anything that increases the number of unbound binding sites lowers the test result. In addition to hypothyroidism, a high TBG level (as seen commonly in estrogen-treated patients) will do this. Furthermore, the presence of hemolyzed erythrocytes in the serum to be tested creates considerable variability of test results. Finally, the T_3 tests are very temperature- and time-dependent, these factors impairing reproducibility.

A study by McAdams and Reinfrank[17] of the Abbott Laboratories' Triosorb T_3 uptake test indicated that it correctly diagnosed 68 of 75 nonpregnant euthyroids, 28 of 29 hyperthyroids, but

of 19 hypothyroids. Similarly, a study done by Meckelnburg, et al[18] concluded that the Abbott test was efficacious in separating hyperthyroids from euthyroids but was generally unreliable in separating hypothyroids from euthyroids.

The Free Thyroxine Index (FTI, T-7)

Since the object of most in vitro thyroid function tests is to assess the blood concentration of free thyroxine (FT_4), attempts have been made to combine the results of either the PBI or T_4 test with the results of the T_3 uptake test to obtain an estimation of this elusive value. Since abnormalities in TBG and TBG binding site concentrations cause the T_4 and T_3 uptake results to move in opposite directions, and since both T_4 and T_3 uptake tests involve proportionalities, the logical maneuver was to multiply the T_4 value by the T_3 uptake. In short, $T_4 \times T_3$ uptake = FTI. The lower and upper limits of normal for the FTI were obtained by multiplying together first the lower normal values for each test and then the upper normal values. It was hoped that the range of normal so calculated would be unaffected by drug therapy or disease states other than hypothyroidism or hyperthyroidism.

The currently well-advertised "T-7" value is simply the FTI calculated from Abbott Laboratories' T_4 and T_3 uptake test kits. It has no special significance.

Advantages: Studies[3,19-24] have thus far shown the FTI to be usually reliable in situations characterized by abnormal protein binding (estrogen therapy, pregnancy, contraceptive medication, nephrotic syndrome). Most clinically euthyroid patients having abnormal levels of TBG will fall into the normal range of the FTI. Haworth and Maclagen[20] concluded that the FTI proved to be quite reliable for the diagnosis of hyperthyroidism and fairly reliable in hypothyroidism. They had "some doubts" regarding its sensitivity in patients with early or partial hypothyroidism.

Disadvantages: In one study,[24] it was observed that the FTI (in this case Abbott's T-7) for normal or estrogen-treated patients tended to be higher than that found in pregnant or sick euthyroid patients. Also, 4 of 25 estrogen-treated patients were "slightly outside the normal range," since estrogen apparently elevated the T_4 value more than it lowered the T_3 uptake. Another study[21] indicated that the FTI was somewhat higher in patients taking birth control pills for 6 to 12 months than in patients on the pill for longer than 12 months. Also, it must be borne in mind that since the FTI is a calculated value, it *multiplies* the inherent error of each test value. Although studies[25] indicate that the Murphy-Pattee T_4 test is reproducible on duplicate tests to within ± 0.5 μg per 100 ml (normal range 4.9 to 9.7 μg per 100 ml reported as T_4 iodine) and that the T_3 uptake is reproducible to within ± 1 percent (normal range 25 to 35 percent),[17,24] it has been reported that the T_3 uptake can vary by as much as 2 to 3 percent on duplicate tests.[26] With such relatively poor reproducibility, one should question the diagnostic value of the resultant calculated FTI in borderline cases. Finally, the FTI will not reflect high levels of serum T_3 and will classify patients on T_3 therapy as hypothyroid despite a clinical euthyroid status. The PBI, T_3 uptake, and T_4 tests are no better in this respect.

It has been noted[27] that a major fault with the FTI's is the nonlinear relationship between the T_3 resin uptake and the level of unbound TBG binding sites, such that the large increases in unbound binding sites from contraceptive medications are not followed by proportionately large decreases in T_3 uptake. This accounts for the high FTI's of some euthyroid patients on birth control pills. To correct for this, at least partly, the "free thyroxine factor" was devised. Here, the T_4 or PBI is multiplied by a factor based on the T_3 uptake reaction mechanics:

$$\text{free thyroxine factor} = T_4 \times \frac{3.5 + T_3 \text{ uptake}}{65 - T_3 \text{ uptake}}$$

The mean free thyroxine factor of these patients is almost, but not quite, down to the level of unmedicated euthyroid individuals.

Other Tests

Although the tests discussed above are the principal ones in use currently, others have been demonstrated that offer various advantages and disadvantages.

Free Thyroxine

Two methods have been described that give a "free thyroxine fraction" (FT_4F).[3,22,28] This value is the fraction of the total serum T_4 that is unbound and hence physiologically active. In the equilibrium dialysis method of Sterling and Brenner,[28] radiolabelled T_4 is added to the patient's serum and the labelled and unlabelled free T_4 allowed to dialyse for 16 hours across a cellophane membrane into a buffer solution. The ratio of radioactivity crossing the membrane to the radioactivity of the original serum sample is equal to the free thyroxine fraction. In the sephadex filtration method,[22] labelled T_4 is added to plasma and the solution poured over a sephadex column. The free T_4 stays on the column and the protein-bound T_4 passes through. The ratio of radioactivity remaining in the column to that counted in the original sample produces the free thyroxine fraction. When the free thyroxine fraction is multi-

plied by the total thyroxine value (as might be obtained from the Murphy-Pattee test), the result is the absolute free serum thyroxine concentration. The free thyroxine fraction fluctuates in a manner similar to the T_3 uptake. It is decreased in pregnancy and during estrogen therapy,[29] a result to be expected from the increase in bound T_4. The fraction is poor as a sole determinant to diagnose thyroid dysfunction. However, the calculated free serum thyroxine does not fluctuate with medication or changes in protein binding. Difficult, expensive, and time-consuming as it is to perform, this free thyroxine value is currently the most accurate in vitro gauge of thyroid status.

The T_3 Assay

On occasion, a patient is found with clinical manifestations of hyperthyroidism but normal or low T_3 uptake, T_4, and PBI. Such patients have been found to have higher than normal serum values of T_3 (triiodothyronine). Since the serum levels of this hormone are in the tenths of micrograms per hundred ml of serum, even in T_3 hyperthyroidism, the conventional tests will not be affected noticeably. (A similar state occurs in patients during T_3 replacement therapy.)

T_3 is assayed clinically by the technic of Sterling, et al.[30] Radiolabelled T_3 (T_3*) is added to the patient's serum and the mixture poured over a cation exchange resin column. The T_3, T_3,* and T_4 present are eluted from the column and the T_3-T_3* fraction then separated from the T_4. The T_3* acts as a marker for identification. The quantity of T_3 originally present is then assayed by a modification of the Murphy-Pattee competitive protein-binding technic.

The data available at present[31] indicate that the T_3 assay's primary value lies in identifying T_3 hyperthyroidism. Values may also be elevated markedly in classic T_4-predominant hyperthyroidism; and they may be lowered, along with T_4, in hypothyroidism.

The TSH Assay

Thyroid stimulating hormone (TSH, thyrotrophin) provides the normal physiologic stimulus to the thyroid gland to synthesize and release the thyroid hormones. Anti-TSH immunoglobulins have been developed and provide the basis for the clinical assay for this hormone.[32]

A known quantity of anti-TSH is added to patient serum. The patient's TSH binds to part of the anti-TSH. A known quantity of radiolabelled TSH (TSH*) is then added to bind with whatever anti-TSH has been left unreacted. By addition of antiimmunoglobulin immunoglobulin, the anti-TSH and anti-TSH* complexes are precipitated. Counting the radioactivity in the original solution and the radioactivity of the precipitate provides a ratio that quantitates the patient's TSH activity (when compared with appropriate standards).

The tests's primary value is to confirm the diagnosis of primary hypothyroidism, since values are almost always elevated in this condition. The test is not precise enough to quantitate the subnormal values of TSH that would be expected in pituitary hypothyroidism or in the Graves' or Plummer's forms of hyperthyroidism. In fact, 50 percent of euthyroid patients have values too small to be measured accurately by this test.[33]

The LATS Assay

Long acting thyroid stimulator (LATS) is an IgG-class immunoglobulin believed responsible for the ophthalmopathy and hyperthyroidism of Graves' disease. The clinical assay available at present is a bio-assay in which animals are injected with the LATS-containing fraction of patient serum and then observed for increased thyroid activity. The chemical groundwork has now been laid for a truly in vitro assay which hopefully will be less tedious and costly than the presently available method.[34] The new technic employs "electrophoretic focusing."

The test's only value lies in evaluating the hyperthyroid patient for Graves' disease. High LATS levels have been found in approximately 90 percent of patients with this disorder.

Other Tests

The various tests described above are all available to the clinician at the time of this writing. Other procedures, methods still in the research stage, will now be considered briefly.

Gas-Liquid Chromatography

Although this method of quantitating thyroid hormones has not yet been extensively evaluated clinically, it has shown itself to be a very effective means of separating and assaying prepared solutions of T_4, T_3, T_3' (L-3, 3', 5'-triiodothyronine), and diiodo- and monoiodo-tyrosines (T_2 and T_1). An important hindrance to its clinical application is the necessity to separate the thyroid hormones from other serum components before analysis can be done.[35]

T_4 and T_3 Immunoassay

Immunoglobulins developed against T_4 and T_3 have been used in a manner analagous to the TSH immunoassay to accurately and specifically assay serum T_4 and T_3.[36] The method is claimed to have picogram precision and, in one large study,

quantitated serum T_3 levels with accuracy approaching that of the Sterling method.[37]

^{32}P Uptake by RBC

Based on the principle that the thyroid hormones stimulate the erythrocyte's incorporation of phosphate from plasma, a test has been developed whereby the patient's whole blood is incubated with ^{32}P phosphate and the amount of radioactivity taken up then measured as a guide to thyroid status.[38] The theoretic advantage of this test is that it measures metabolic stimulation rather than hormone levels. The small number of subjects evaluated by this method does not permit conclusions relative to diagnostic efficacy to be drawn.

Discussion

From the foregoing data, from personal communication, and from experience with currently popular tests, it is concluded that the T_4 test based on the Murphy-Pattee principle is the most accurate single in vitro aid in thyroid diagnosis. The test's good reproducibility, freedom from iodine interference, and specificity in measuring only T_4 each provides theoretic validity of the test's worth. Critical evaluations and current reports indicate that T_4 test results agreed with the other clinical findings more often than either the T_3 uptake or the PBI tests. In patients who were not pregnant or taking oral contraceptives or had otherwise altered binding of T_4 to TBG, the T_4 test was even more reliable than the FTI. Whereas the FTI values tended to place patients with mild hypothyroidism in the normal range, the T_4 test usually was concordant with the clinical impression.

The T_3 uptake, although less precise than the T_4 test, is of value in confirming the diagnosis of hyperthyroidism. Since most, but not all, factors influencing the test tend to lower the result, an abnormally high T_3 uptake is considered more significant than a low one. Likewise, the T_4 and PBI tests are considered more significant when low than when high and are, therefore, more effective in confirming a diagnosis of hypothyroidism than one of hyperthyroidism.

The PBI should probably only be used to confirm hypothyroidism, as in this condition a low result is usually significant. A normal or high result is less reliable, since either iodine contamination or abnormal TBG levels may be interfering.

The FTI value, the mathematical product of the T_4 test and the T_3 uptake, reduces the problems associated with abnormal binding of T_4. It is not as sensitive as the T_4 test in borderline hypothyroidism. In general, the FTI seems better suited to confirm clinically probable diagnoses than to exclude marginal thyroid dysfunction. The complexly calculated free thyroxine factor multiplies the T_4 test by a number calculated from the T_3 uptake. It may enhance both the sensitivity and accuracy of the T_3 and T_4 tests by correcting for inherent defects in quantitation of the T_3 uptake. The absolute free serum thyroxine value is probably not sufficiently better than the free thyroxine factor to warrant the extra time and expense involved in obtaining it.

The TSH, LATS, and T_3 assays are all highly specialized tests useful in selected patients with known or probable thyroid dysfunction. They are each capable of providing valuable information, but none is a screening test and all are expensive.

For the clinician, the question of which test to order is a vexing one. The following points seem valid.

1. To screen for hypothyroidism, obtain a T_3 uptake test; to confirm it, obtain a T_4 test.
2. To screen for hyperthyroidism, obtain a T_4 test; to confirm it, obtain a T_3 uptake.
3. Where abnormal hormone binding or altered blood proteins are suspected, calculate the FTI or free thyroxine factor.
4. If doubt remains after these values are known, obtain a radioiodine uptake (and scintiscan) and/or test the patient's response to thyroid stimulation or suppression, as applicable.

Summary

Of the various in vitro thyroid function tests now readily available to the physician, the Murphy-Pattee type T_4 test is the most specific and overall the most accurate test. The protein-bound iodine test (PBI), although precise, is the least specific and hence the least reliable test. The T_3 uptake tests, while perhaps more efficacious than the PBI, are less specific, less precise, and less reliable than the T_4 tests. The free thyroxine indices are more accurate than any of these individual tests when abnormal protein binding of T_4 occurs, but they may still provide erroneous values in some patients.

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Toluidine Blue Staining of Metastatic Carcinoma to the Oral Cavity

Henry N. Maimon, M.D., and Alan D. Steinfeld, M.D.

THE DIAGNOSIS of neoplasm by toluidine blue stain has been useful in delineating lesions of the oral cavity and uterine cervix.[1,2] Earlier studies indicated that in vivo toluidine blue staining of oral neoplasms was helpful in (1) the detection of carcinoma in situ; (2) the recognition of small, early invasive carcinoma; (3) delineation of the margins of larger epithelial neoplasms; (4) the recognition of postsurgical marginal recurrence; (5) the recognition of recurrence or new lesions postirradiation; (6) the delineation of areas of field cancerization and surface margins; and (7) the detection of occult second primary cancers or satellite tumors.[3,4] Myers extended the usefulness of this test by the description of positive staining in ulcerated tumors such as melanoma, fibrosarcoma, and lymphosarcoma, in addition to epidermoid cancer.[5]

To date, the toluidine blue staining procedure has been used only on primary neoplasms in the cervix and oral cavity. In this case, the technique has been used successfully to stain a metastatic lesion of the oral cavity.

Report of a Case

A 52-year-old Negro man entered Cincinnati General Hospital for the first time on October 6, 1970 complaining of cough, weight loss, and scattered skin nodules of at least three weeks duration. Chest roentgenogram showed a grapefruit-sized "snowball" in the right upper lung field. Physical examination revealed a 3 X 2 cm mass on the left upper gingiva (Fig. 1-left), in addition to firm, 1 X 2 cm masses in the right supraclavicular fossa, left axillary and inguinal areas, and on the right chest wall and left buttock.

The lesion was stained in the following manner: (1) One percent acetic acid was applied to the area with a cotton applicator to remove mucous. (2) A small amount of 1 percent toluidine blue solution was applied with a cotton applicator to the oral mucosal lesion and adjacent normal mucosa (Fig. 1-center). (3) The patient then rinsed his mouth several times with water. The gingival lesion appeared royal blue while the decolorized normal mucosa was free of dye (Fig. 1-right). Biopsies of a scalene node and the gingival lesion were reported by the pathologist as poorly differentiated metastatic squamous cell carcinoma with the primary site likely to be the

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FIG. 1. Gingival lesion prior to staining with toluidine blue (left); gingival lesion and adjacent normal tissue stained with toluidine blue (center); and gingiva following decolorization with water (right). Note retention of stain by lesion.

lung. He was treated symptomatically and discharged on November 15, 1970. He was readmitted on November 27, 1970 dehydrated and obtunded. The patient died on November 30, 1970. Autopsy revealed bronchogenic carcinoma with metastases throughout the body.

Comment

Toluidine blue is a nuclear stain. Richart found that the affinity and intensity of cervical epithelial staining appeared clinically to be closely related to the number of nuclei per unit area. This could account for the false positive reactions produced by infiltrates of inflammatory cells. Following the water decolorization, columnar epithelium and inflammatory areas usually stain deep blue-black, while the neoplastic section stains royal blue.

In previous studies, the efficacy of the toluidine blue staining procedure in identifying oral carcinomas has approached 95 to 100 percent. Of 70 cases reported by Myers, no false positives were noted. However, false positive reactions have been reported with traumatic ulceration, granulation tissue, fissured leukoplakic lesions,[3] and in the presence of mucin, food, or purulent exudate.[6] False positives due to traumatic ulceration may be excluded by history. Those due to mucin, food, or purulent exudate may be removed by the acetic acid and water rinses. Granulation tissue and fissured leukoplakic lesions may require additional diagnostic methods. A study by Shedd, et al in 1968, indicated that 42 patients with neoplastic lesions all had positive staining responses. Twenty patients with non-neoplastic lesions demonstrated three false positive tests, two of which were inflammatory lesions and one of which was hyperplastic lymphoid tissue. Twenty-three subjects with no known oral lesions revealed no positive staining. A comparative study of exfoliative cytology in 23 patients with malignant lesions revealed 15 positive for carcinoma, 6 abnormal but nondiagnostic of carcinoma, and 2 false negatives.

Several approaches to the diagnosis of oral neoplasms are in current use and each contributes.[7] The positive toluidine staining of primary oral cancer is relatively constant. The diagnosis of metastatic carcinoma to the oral cavity by this approach is readily available to the clinician.

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Respiratory Acidosis During Thoracotomy

Carl G. Schowengerdt, M.D., and John L. Hunt, M.D.

ARTERIAL BLOOD GAS and acid-base studies are not routinely used in patients undergoing pulmonary surgery. Homeostatic alterations may be severe in these patients, however, and are particularly seen in those with limited pulmonary function and those in whom unilateral bronchial occlusion is used during the operative procedure. Although it seems a truism, it is nevertheless important to emphasize that the major cause of morbidity and mortality following pulmonary surgery is respiratory dysfunction. Postoperative mortality and morbidity in these patients are directly related to the respiratory management which is given.

It also seems important to emphasize that arterial blood gas and acid-base studies are the only reliable means of determining a patient's respiratory state during and after thoracotomy. No other means of clinical evaluation or laboratory test gives early enough indication of respiratory function to avoid serious morbidity and mortality. The following clinical study and discussion are therefore intended to point out the value of routine blood gas studies in patients undergoing pulmonary surgery.

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Materials and Methods

A total of 32 patients undergoing thoracotomy at the Cincinnati Veterans Administration Hospital were studied during the one-year period of May 1969 through April 1970. Of these 32 patients, five were subjected to pneumonectomy, 12 to lobectomy, and seven to wedge resection or resection of emphysematous lung and bullae. A total of 24 patients, therefore, underwent lung resection. An additional eight patients underwent thoracic exploration or exploration and biopsy

only. Carcinoma of the lung was present in 20 patients, benign lesions of the lung were present in 11 patients, and in one patient, a foreign body (intravenous catheter) was extracted from the left pulmonary artery.

Patients were usually premedicated with a barbiturate, opiate, and atropine, although no set premedication dosages were used. Upon arrival of the patient in the operating room and prior to the administration of any anesthesia, a femoral artery puncture was employed for procurement of the first blood gas sample. General anesthesia was then instituted and a Carlens double-lumen endotracheal catheter was inserted. Both hemithoraces were thoroughly checked by stethoscope and alternate occlusion of sides to ascertain proper position of the catheter. The patient was then placed in the lateral decubitus position with a rolled towel under the dependent shoulder and with table flexion of a few degrees under the dependent hemithorax.

Prior to positioning of the patient, an arterial line was established in the radial artery of the arm opposite the thoracotomy site. The presence of an ulnar pulse and patent palmar loop were ascertained, and under aseptic technique, a 1.5-cm incision was made over the radial artery. The artery was exposed, retracted, and a No. 16 Jelco catheter over needle was inserted. No arterial ties were employed. The catheter was anchored well with an additional stitch, and the wrist was supported with a board. Luer-lock connections were used throughout, and the arterial catheter was connected through a stiff, dilute heparin-saline filled line to a balanced Hewlett-Packard 1280A pressure transducer. Transducer impulses were fed to a balanced Hewlett-Packard 1309A monitor and 5601A digital read-out display. The arterial line was irrigated as needed, without exerting pressure on the transducer. Arterial blood pressure was monitored throughout the operative procedure and for as long afterward as was desired. Arterial blood samples were drawn at specified points in time throughout the operation and at other times as indicated.

A minimum of 15 minutes was allowed for stabilization after each of these specified points in time, and arterial blood samples were drawn after: (1) establishment of general anesthesia, endotracheal intubation, and positioning of the patient; (2) thoracotomy; (3) occlusion of the bronchus of the operative lung; (4) pulmonary resection; (5) closure of chest; and (6) transfer to recovery room. Samples were submitted for determination of pH, pO_2, pCO_2, buffer base, and bicarbonate level, using the Astrup method.

All patients were supported postoperatively for 4 to 24 hours on a Bennett PR 2 or Bird Mark 8 ventilator, using a cuffed endotracheal or nasotracheal catheter, and regulating the oxygen concentration, pressure, and respiratory rate according to additional blood gas determinations. Ventilation was discontinued when patients were fully awake, stable, and had demonstrated by blood gas determinations their capability of fully resuming their own ventilatory function. In two patients requiring ventilatory support for more than 48 hours, tracheostomy was performed.

Arterial lines were not maintained for more than 48 hours. Following its use, the line was withdrawn, and pressure was applied over the artery for 10 minutes. No re-exposure of the vessel was necessary.

Results

Average Values

The average values for the arterial samples obtained are shown in Table 1. Patients tended toward acidosis, hypercapnia, and hypoxemia under the effects of premedication but promptly corrected these values with the institution of general anesthesia. There was a tendency toward acidosis with unilateral bronchial occlusion and again upon completion of the operation and transfer of the patient to the recovery room. Arterial oxygen pressure was easily maintained at normal or above normal level throughout all cases.

Table 1. Average Arterial Blood Samples

	pH	pCO_2	pO_2
Preanesthetic	7.370	42.1	79
Postintubation	7.429	33.3	191
Thoracotomy	7.446	32.0	131
Unilateral bronchial occlusion	7.407	35.5	118
Specimen out	7.416	33.7	166
Chest closed	7.371	36.4	198

The degree of the problem cannot be appreciated without singling out those patients who became distinctly acidotic (Table 2). Assuming a normal pH range of 7.35 to 7.45, seven of the 32 patients (21.9 percent) were found to be acidotic

Table 2. Average Arterial Blood Samples in Patients with Acidosis ($pH < 7.35$)

	No.	pH	%
Preanesthetic	7	7.300	21.9
Postintubation	6	7.314	18.8
Unilateral bronchial occlusion	8	7.280	25.0
Chest closed	10	7.306	31.2

to the institution of anesthesia, with an average pH of 7.300. After endotracheal intubation, six of the patients were acidotic, and after unilateral bronchial occlusion, seven became acidotic. By the end of the operation, ten (31.2 percent) of the patients were distinctly acidotic, with an average pH of 7.306.

Patterns of Acidosis

An attempt was made to determine the predictive significance of acidosis occurring at any one point during the operative procedure. In this process, two particular patterns were detected. In examining those patients who were acidotic after intubation (Fig. 1), or those who became acidotic after unilateral bronchial occlusion (Fig. 2), it became apparent that these patients had particular

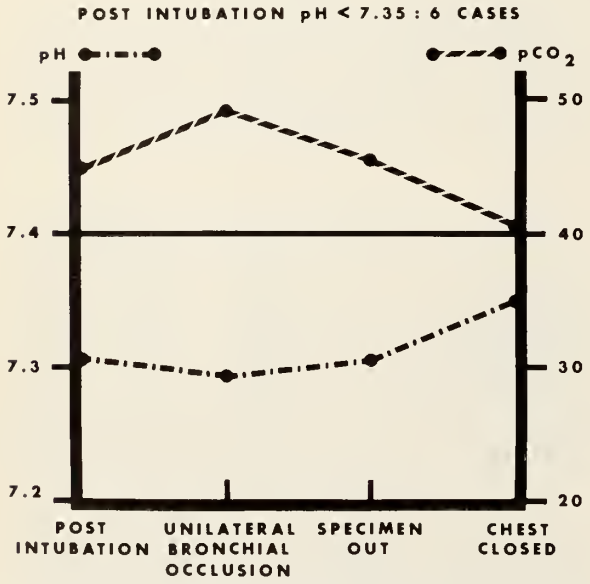


Fig. 1. Pattern of acidosis developing after endotracheal intubation. Correction of arterial pH and pCO_2 toward normal was achieved by end of operative case.

difficulty during the time of unilateral lung ventilation, recovering after the resection was completed. The other distinct pattern was seen in those patients in whom acidosis did not develop until after the specimen was removed (Fig. 3). This pattern appeared more ominous, indicating the need for continued respiratory support and attentive care during the early postoperative period.

Complications

Of the total 32 patients, major complications occurred in seven. Postoperative pneumonia occurred in two, lobar collapse in two, empyema in one, wound infection in one, and persistent air

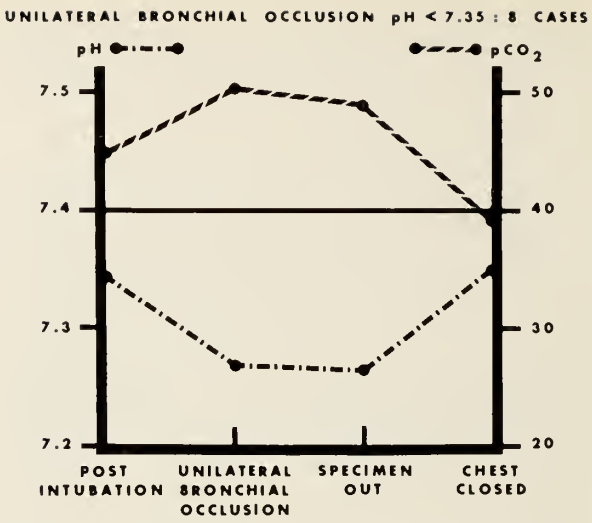


Fig. 2. Pattern of acidosis developing after unilateral bronchial occlusion. Correction of arterial pH and pCO_2 toward normal levels was achieved by end of operative case.

leak in one. Further procedures required in the treatment of these complications were limited to tracheostomy in two patients, repeated bronchoscopy in two, and chest drainage in one.

Mortality

Of the total 32 patients, one died during the first 30 days after operation, this being a patient with superior vena cava syndrome in whom exploration was necessary to establish a diagnosis of adenocarcinoma of the mediastinum. He died as a result of the caval syndrome and not because

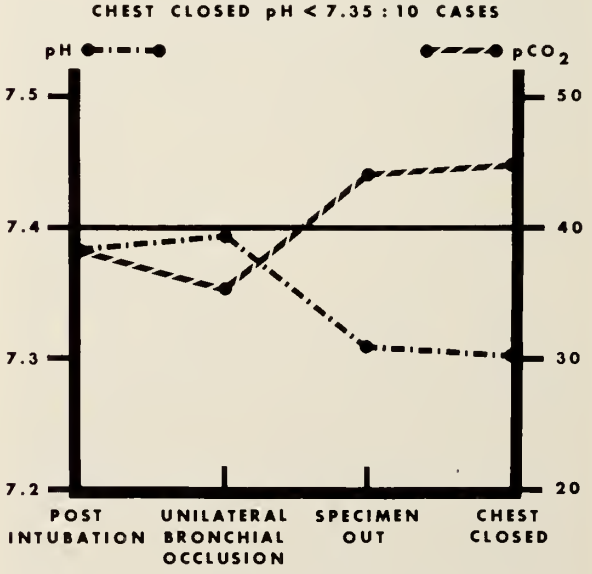


Fig. 3. Pattern of acidosis developing after removal of specimen. Short-term postoperative ventilatory support was a necessity in these patients.

of any other postoperative difficulty. There were no other deaths; the postoperative mortality rate was therefore zero percent in those 24 patients undergoing lung resection during this study.

Discussion

As early as 1922, Van Slyke, Austin, and Cullen demonstrated that carbon dioxide retention and acidosis occurred with the administration of general anesthesia in a rebreathing system.[1] The deeper the anesthesia obtained, the more severe the acidosis became. As shown by Stormont and his colleagues, the anesthetized subject has no response to elevated levels of carbon dioxide, and in the presence of hypoventilation, he develops severe carbon dioxide retention with acidosis, regardless of the use of absorption cannisters.[2] In studies performed by Miller and his associates, as high as 35 percent of patients undergoing general anesthesia were found to have severe elevations of alveolar carbon dioxide.[3] Maier, Rich, and Eichen found moderate degrees of acidosis within 15 minutes after inhalation anesthesia was begun.[4]

The prevalence of this problem, particularly in patients undergoing thoracic surgery, has been well documented in the past. Beecher and Murphy, using intermittent assisted ventilation, found an average postoperative pH of 7.09 and an average postoperative pCO_2 of 60.3 mm Hg in 43 patients.[5] Taylor and Roos cited one example of a patient undergoing pneumonectomy who developed a pH of 6.86 and pCO_2 of 170 mm Hg.[6] Acidosis and hypercapnia were not as severe in those series in which cuffed endotracheal tubes and mechanical ventilators were used, but nevertheless they occurred routinely. Stead, Martin, and Jensen found average pH levels of 7.155 and pCO_2 levels of 82 mm Hg in patients undergoing thoracotomy.[7] Gibbon and his colleagues pointed out that acidosis and carbon dioxide retention were more severe in patients undergoing lung resection, particularly in those undergoing pneumonectomy.[8]

During the last decade, considerable investigative work has demonstrated that these deficiencies of respiratory exchange are due to ventilation perfusion abnormalities both in the dependent and the nondependent lung. As shown by Hatch[9] and also by Rehder, Theye, and Fowler,[10] the dependent lung is relatively underventilated and overperfused, while the operative lung is overventilated and underperfused. These disparities are augmented by occlusion of one limb of a double-lumen endotracheal catheter. At this time there are two lungs perfused and only one ventilated. The one ventilated lung is compressed, is highly subject to atelectasis, and is often unable to maintain proper ventilation without some correction in the amount of air moved. The patient with ample pulmonary reserve may have no difficulty, but the patient with even moderate restriction of function is highly subject to respiratory insufficiency when reduced to the use of one restricted lung. As was clearly demonstrated by Virtue, et al, compensatory adjustment in minute-volume of air moved must be made to prevent significant carbon dioxide retention.[11] Laver and Seifen made an important contribution by pointing out that atelectasis in the dependent lung, which plays a significant role in the ventilation perfusion disparity, can be largely avoided by the intermittent use of deep inflation of the lung.[12]

With these problems occurring even more readily in patients who have the bronchus of the operative side occluded, one might question the practicality of using double-lumen endotracheal catheters, designed for deflation of the lung on the operative side. There are advantages of this technic. With the lung deflated, the dissection can be made thoroughly, major vessels can be reached easily and ligated securely with wide cuffs, and closure of the bronchus can be done carefully without air leak. Against these, one must weigh the problems of respiratory exchange and acid base balance, which may be augmented by unilateral bronchial occlusion.

Adequate postoperative ventilatory support is just as important as the intraoperative management of ventilation and acid base balance. There is a dangerous hiatus in intensive care which occurs during transfer of the patient from the operating room to the intensive care area. If the half-conscious patient is extubated, detached, moved, and left suddenly in the care of a different person, further respiratory problems can be expected. It has been amply demonstrated that the ventilation-perfusion disparities — atelectasis, hypoxemia, hypercapnia, and acidosis — which have developed during the operation, will continue well into the early postoperative course. Without short-term ventilatory support, there is high risk of the occurrence of sudden cardiac arrest in the deeply acidotic hypercapnic patient, who is unable to resume his own ventilatory function.

It cannot be emphasized strongly enough that the usual clinical signs are of little value in determining whether or not a patient is acutely hypoxic, hypercapnic, or acidotic. There is no clear indication until cardiac arrhythmia occurs, and there is no reliable method of forewarning other than determination of the arterial pH, pO_2, and pCO_2.

For these reasons, short-term postoperative ventilatory support appears to be a necessity in patients undergoing lung resection. The preferable method is to use a nasotracheal catheter and a

demand respirator, adjusting pressure, rate, and oxygen flow as indicated by additional blood gas determinations. The usual patient will be sufficiently stable within 4 to 24 hours to fully resume his own ventilatory function.

Close attention to these ventilatory problems will provide an appreciable reduction in morbidity and mortality after thoracotomy. For example, during the five-year period beginning May 1, 1964 and ending April 30, 1969, there were 17 postoperative deaths in 109 patients undergoing lung resection at the Cincinnati Veterans Administration Hospital, a mortality rate of 15.6 percent (Table 3). For the year of this study, May 1, 1969 through April 30, 1970, during which the respiratory state of the patient was carefully monitored and emphasized, there were no postoperative deaths in 24 patients undergoing lung resection. The major factor in this improvement

Table 3. Mortality Rate Within 30 Days (May 1964 through April 1969)

Wedge resections	1/23	4.3%
Lobectomy	8/58	13.8%
Pneumonectomy	8/28	28.6%
Total	17/109	15.6%

was the routine determination of blood gas and acid-base levels to guide the respiratory management of these patients.

Summary

Respiratory acidosis occurring during thoracotomy is particularly evident in patients in whom resection of lung tissue is performed, and in whom unilateral lung ventilation is used during the procedure.

The respiratory acidosis that occurs is due to ventilation-perfusion disparities in both the dependent and operative lungs, with atelectasis being one of the prime anatomic factors.

The respiratory acidosis that occurs usually can be corrected by upward adjustments in minute-volume of ventilation to the unilateral lung and by the intermittent use of deep inspirations.

The usual clinical signs are of little value in determining the presence of acute hypoxia, hypercarbia, or acidosis. The only method of determining these serious homeostatic alterations early enough to prevent serious morbidity or mortality at present is that of the routine use of blood gas determinations during and after pulmonary resection.

Using these determinations routinely in a one-year prospective study of patients undergoing lung resection was a major factor in reducing the postoperative mortality rate to zero percent, as compared to a postoperative mortality rate of 15.6 percent for the previous five years.

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Amniotic Fluid Cytology for Assessment of Fetal Maturity

Narendra S. Doshi, M.D., and Amir H. Ansari, M.D.

ASSESSMENT of fetal maturity is a constant challenging problem to the obstetricians, particularly in high risk pregnancies where induction of labor or elective cesarean section are often contemplated. Furthermore, factors such as history of gross menstrual irregularities, maternal diabetes, and placental insufficiency may inadvertently interfere with the usefulness of history and clinical findings, the practical means of estimating fetal maturity. Even radiologic methods, although more informative than previously mentioned approaches and aside from their potential radiation hazards, are associated with certain miscalculation and uncertainty.[1] On the contrary, in recent years determination of creatinine, bilirubin, and certain cellular components of the amniotic fluid have proven to be highly informative and valuable diagnostic methods. The purpose of this presentation, therefore, is to present the result of amniotic fluid cytology for determination of fetal maturity in our institution from November 1969 to June 1971.

Material and Methods

A total of 43 amniotic fluid samples were analyzed from 37 parturients. Analyses were performed once in 34 cases, twice in one patient, thrice in one case, and four times in the remaining one patient. The patients' ages ranged from 14 to 42 years with mean average of 23 years. Samples were obtained 23 times by percutaneous amniocentesis under local anesthesia, direct tapping of the uterus at the time of cesearean sections in 19 occasions, and one sample was obtained by means of vaginal amniotomy for induction of labor. Table 1 illustrates the distribution of patients in whom amniotic fluid was analyzed.

Amniotic fluid was examined within one hour after it was obtained, without prior knowledge of gestational age or associated pregnancy complications. Samples which were contaminated by blood or meconium were discarded.

Using 0.1 percent Nile blue sulfate, amniotic fluid was stained and interpreted according to the method of Gordon and Brosens.[2] Two slides were prepared from each sample and 500 cells were

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Reprint requests to Saint Luke's Hospital, 11311 Shaker Blvd., Cleveland, Ohio 44104 (Dr. Ansari).

Submitted July 21, 1971.

The Authors

• **Dr. Doshi, Cleveland, is Fellow, Department of Reproductive Physiology, Saint Luke's Hospital.**

• **Dr. Ansari, Cleveland, is Head, Department of Reproductive Physiology, Saint Luke's Hospital; and Assistant Clinical Professor, Department of Reproductive Biology, Case Western Reserve University School of Medicine.**

Table 1. Distribution of Cases in Whom Amniotic Fluid Cytology Was Performed

Conditions Associated With Pregnancy	No. of Cases
Toxemia of pregnancy	10
Diabetes mellitus	4
Rhesus sensitization	4
Fetopelvic disproportion and previous cesarean section	10
Possible intrauterine growth retardation	4
Possible postmaturity	3
Therapeutic termination of pregnancy for psychiatric reasons	2
Total	37

counted in each slide for a total of 1000 cells. In the event of wide discrepancy between the two slides, an additional 1000 cells were counted. In addition to fat cell count, presence or absence of fat cell clusters and free lipid droplets were also recorded (Fig. 1). Whenever the assessment was made prior to term, the patient was carefully observed until delivery, and the newborn was assessed for maturity according to clinical[3] and neurologic criteria.[4,5]

Result

Of the 43 samples, 17 showed fetal cell count between 10 and 50 percent with most samples having counts over 20 percent. These samples, in addition, contained large numbers of fat cell clusters and/or free lipid droplets. All babies in this group of cases were over 38 weeks of gestation. Twenty-three samples of amniotic fluid contained fetal cell count between 1 and 10 percent. The gestational ages for these 23 samples were 32 to 38 weeks for 19 samples and from 38 to 40 weeks for the remaining four samples. However, despite low fat cell counts in the latter four samples, three contained moderate amounts of fat cell clusters and/or free lipid droplets.* The fat cell count in the remaining three specimens revealed counts below 1 percent without either fat cell clusters or free lipid droplets. These specimens were obtained from two cases of therapeutic abortions at 14 weeks of gestations and a pregnancy of 30 weeks' duration.

There were no positive or negative false results in the case of prematurity. In four mature pregnancies, the fat cell count was recorded below 10 percent and therefore was considered as a false negative result (Table 2). However, as mentioned before, the amniotic fluid in three of these four pregnancies contained a moderate amount of fat cell clusters and/or free lipid droplets which by themselves have been advocated as evidences of fetal maturity.[6]

*Samples of more advanced gestational age (36 to 38 weeks) contained occasional to moderate fat cell clusters and/or free lipid droplets.

Discussion

In recent years, amniotic fluid cytoanalysis has been found useful test for assessment of fetal maturity. It has been shown that these orange stained fat cells originate from the sebaceous glands of the fetal skin. Increase in the number of fat cells, fat clusters, and presence of free lipid droplets therefore reflects functional maturity of the sebaceous glands. It appears therefore reasonable to assume that if sebaceous glands are mature other organs are mature as well.

In this series, 17 of the 21 mature infants were correctly estimated by amniotic cytology for an accuracy of 80.9 percent. False negative results, which also have been reported by others, also occurred in four cases (19.1 percent) according to cell counts.[7] However, in three of these four cases, fat cell clusters and/or free lipid droplets were present in moderate amount which strongly suggested fetal maturity. Therefore, the corrected estimate of fetal maturity for the 21 mature infants in actual fact is 20 out of 21 cases (95.2 percent accuracy). Concurrently all premature infants had a fat cell count of less than 10 percent with fat cell clusters and free lipid droplets being invariably absent except for two cases of advanced gestations (35 to 37 weeks) in whom occasional to few fat cell clusters and/or free lipid droplets were identified.

Follow-up of pregnancies in this study revealed that all infants with fat cell counts over

Table 2. Results of Amniotic Fluid Analyses

Gestational Age (Weeks)	No. of Cases	Fat Cell Count (%)	Clusters	Lipid Droplets	Diagnostic Accuracy Uncorrected (%)	Diagnostic Accuracy Corrected (%)
38-40	17	10-50	14	12	80.9	95.2
	4	1-10	3	3		
34-38	13	1-10	4*	2†	100.0	---
14-32	3	1	0	0	100.0	---

*Only occasional to few clusters
†Only occasional to few lipid droplets

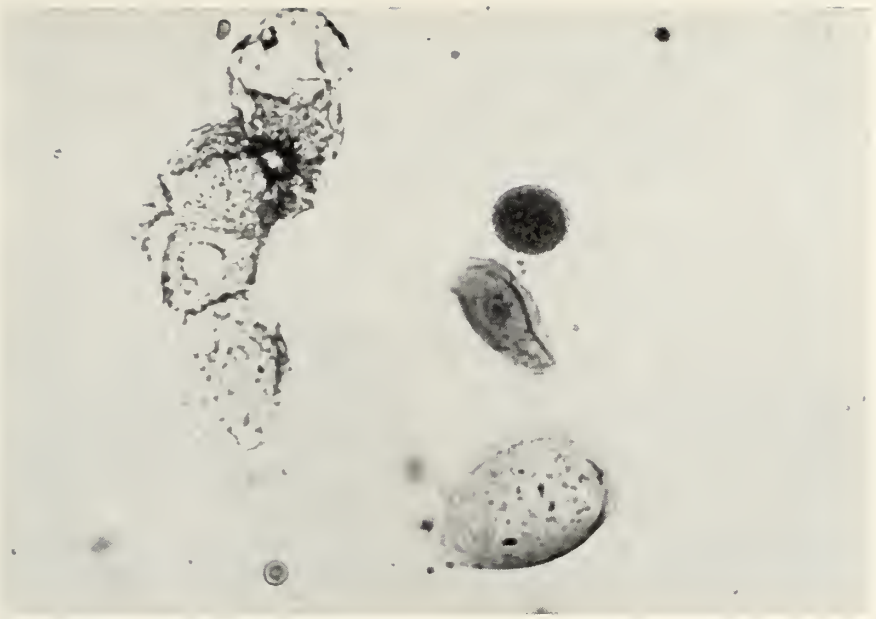


Fig. 1. Nile blue sulfate stained amniotic fluid showing fetal fat cells, fat cell clusters, free lipid droplets, and a single squamous cell.

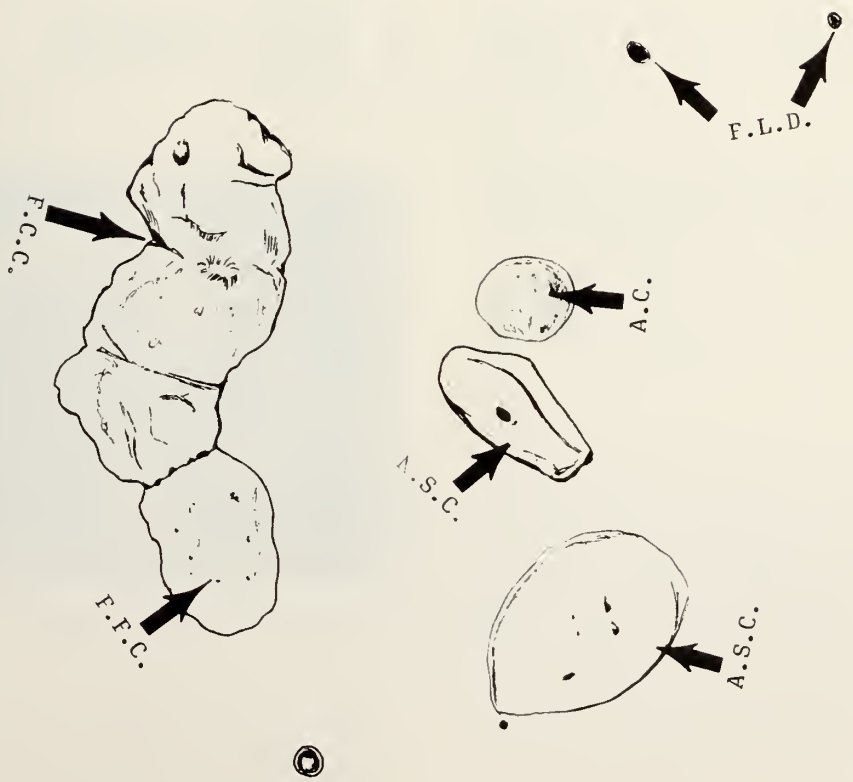


Fig. 2. Schematic representation of Fig. 1. F.C.C. = fat cell cluster; F.F.C. = fetal fat cell; N.S.C. = nucleated squamous cell; A.S.C = anucleated squamous cell; A.C. = anucleated cell; and F.L.D. = free lipid droplets.

10 percent, except for one small-for-date infant (dysmature), registered over 2500 gm at birth. In contrast, the birth weight of the infants with counts less than 10 percent were below 2500 gm, except for four false negative and two preterm infants of diabetic mothers. Furthermore, follow-up of infants after delivery revealed that of 17 mature infants with fat cell counts over 10 percent, only one infant developed transient mild respiratory distress syndrome. On the contrary, three premature infants with fat cell counts below 10 percent developed severe respiratory distress syndrome and died.

In conclusion, amniotic fluid cytology as used in this study and reported by others proved to be useful diagnostic method for estimation of fetal maturity. Furthermore, we believe that in order to increase the diagnostic accuracy of fetal maturity assessment, obstetricians should utilize as many tests as possible, including amniotic fluid cytology, which probably is one of the most informative tests for this purpose.

Summary

Forty-three amniotic fluid cytology analyses were performed for evaluation of fetal maturity in 37 parturients. The test provided a high degree of accuracy and in general was found to be superior to the previously described tests of fetal maturity.

According to this study, in addition to fat cell count, the presence of a moderate to large number of free lipid droplets and/or fat cell clusters by themselves may indicate a mature infant.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 54-year-old man enters with the complaint of a feeling of fullness in his left ear. He has also noticed some decrease in hearing acuity in the ear. Otherwise he has been in excellent health.

Findings from the general examination were normal except for a small amount of amber fluid behind his left tympanic membrane (Fig. 1) and a firm nontender node in the left posterior triangle of his neck.

His hearing was slightly decreased in his *left ear* on gross testing. When the 512-cps tuning fork was placed on his forehead, he "heard" it louder in the *left* ear. Next he was asked to compare the loudness of the fork when its base was placed upon his mastoid bone as opposed to when the tines of the fork were held opposite the ear canal. He heard better by air conduction in his right ear (positive Rinne test) but better by bone conduction in his left ear (negative Rinne). The lateralization of Weber to the left, combined with a negative Rinne point to a conductive or mechanical-type hearing loss. This is what we would expect with serous fluid in the middle ear space.

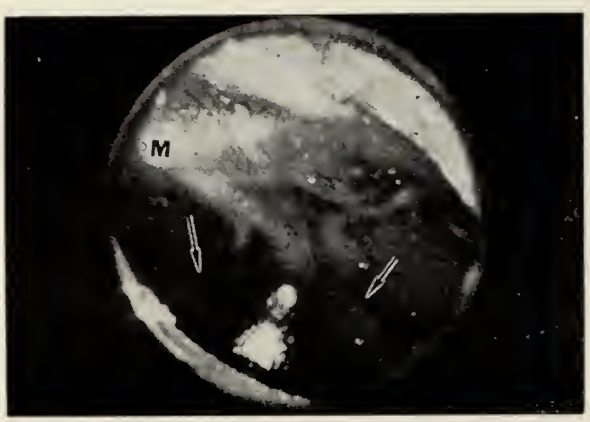


Fig. 1. A small amount of amber fluid was seen behind the tympanic membrane. Arrows point to fluid level. "M" identifies short process of the malleous.

What could be the etiology of the serous otitis? *(See p. 379 of this issue for further information and discussion.)*

*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.

Submitted August 2, 1971.

Too Much Urine

Leonard B. Berman, M.D.*

POLYURIA provides an opportunity to examine the question of how much urine is too much. The definition may be based on usual or expected amounts of urine. Thus, two or more liters per day is a distinctly large urine volume. It may be more physiologically based, ie, a urine volume which equals or exceeds water intake. I prefer a clinical definition — an increase in urine volume which brings the patient to the doctor, tired and sometimes thirsty. Once recognized, the polyuric patient may usually be classified into one of two groups — on the basis of simple examination of the urine and blood.

	Water Diuresis	Solute Diuresis
Urinary specific gravity	1.001 - 1.005	1.009 - 1.035
Urinary osmolality	50 - 150	250 - 320
Blood sodium	Normal or Increased	Normal or Decreased
Thirst	Prominent	Occasional

The pathophysiology of water diuresis is either a lack of antidiuretic hormone or an unresponsiveness of the renal tubule to adequate concentrations of the hormone. Lack of antidiuretic hormone arises from disease or trauma of the posterior pituitary. The unresponsive tubule may be on the basis of an inborn error of metabolism, or of acquired causes such as hypercalciuria, hypokalemia, and hydronephrosis. The consequence in either case is large amounts (2 to 15 liters per day) of dilute urine.

Solute diuresis, on the other hand, is the result of impaired tubular reabsorption of a particular solute resulting in large losses accompanied by water. Clinical examples include glucose in diabetes mellitus, sodium in Addison's disease or following relief of acute bladder obstruction, and urea in uremia.

The clinical presentation of polyuria may vary from urinary frequency to unrelenting thirst. The genitourinary tract undergoes stretching and will finally become hydronephrotic. In any event, polyuria provides the clinician with the occasion for analysis of disordered physiology, and best of all, the possibility of relieving the patient's distress.

*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.

PACEMAKERS FOR HEART BLOCK. — There are a few patients in heart block who manage well without pacing, often for many years, but these are a selected group who have survived the early months, and many have symptoms which restrict their lives. Since a pacemaker might well lessen these restrictions by increasing the ventricular rate its use should always be considered. — Leading Article, *British Medical Journal* 4:442, Nov. 20, 1971.

Professional Activities



Proceedings of The Council

Meeting of February 12-13, 1972

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, February 12 and 13, 1972, in the OSMA headquarters office, 17 South High Street, Columbus.

Those present on Saturday, February 12, were: All members of the Council; Mr. James E. Pohlman, Columbus, legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Drs. Henry A. Crawford, Cleveland; Harry K. Hines, Cincinnati; Robert P. Johnson, Middletown; H. William Porterfield, Columbus, AMA Delegates and Alternates; Dr. Milton M. Parker, Columbus, Chairman of the Committee on Mental Health; Mr. William J. Lee, Columbus, Administrator of the State Medical Board; Mr. Bernard D. King, Columbus, representative of the Student American Medical Association; Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Moore, and Mrs. Wisse of the OSMA staff.

Those present at the meeting on Sunday, February 13, were the following: All members of the Council; Mr. Pohlman; Dr. Budd; Dr. D. J. Vincent, Columbus, Secretary of the OSMA Section on Directors of Medical Education; Dr. Anthony Ruppersberg, Jr., Columbus, Chairman of the OSMA Committee on Maternal Health; and all members of the executive staff except Mrs. Wisse.

Candidates for Office

President-Elect

A communication from the Gallia County Medical Society, nominating Oscar W. Clarke, M.D., Gallipolis, Ninth District Councilor, for the office of President-Elect of the Ohio State Medical Association, was received by the Council.

Seventh District Councilor

A communication from the Tuscarawas County Medical Society, announcing the candidacy of Robert R. Rinderknecht, M.D., Dover, as a candidate for the Seventh District Councilor, was received by the Council.

Minutes Approved

Minutes of the meeting of the Council held December 11-12, 1971, **were approved** by official action.

Membership

A review of membership statistics for 1971 by Mrs. Wisse indicated a net gain over 1970 of 103 members, a total of 10,314. Of this number 80.6% were members of the American Medical Association.

Auditing and Appropriations

The Council **adopted** a resolution authorizing two of the following three signatures on checks

for *The Ohio State Medical Journal:* Oscar W. Clarke, M.D., Hart F. Page, Katherine E. Wisse.

Minutes of the February 11, 1972 meeting of the Auditing and Appropriations Committee were presented by Mrs. Wisse and **were approved** as presented.

Immunization Campaign Endorsed

An immunization program proposed by the Ohio Director of Health to raise the level of immunization against rubella and rubeola **was endorsed** by the Council.

Economic Stabilization Program

Dr. McLarnan reported that the Ohio Hospital Advisory Council has been designated by Governor John J. Gilligan to consider the health services aspects of the Economic Stabilization Program.

The Council will review applications from institutional providers of health services filed with it for exceptions, pursuant to the guidelines established by the Price Commission.

Individual providers, including physicians, will apply direct to the Internal Revenue Service for exceptions.

Councilor Reports

The Councilors reported on activities in their respective districts.

American Medical Association

Delegation Meeting

It was announced that the OSMA delegates to the American Medical Association, in session February 11, 1972, nominated Richard L. Meiling, M.D., Columbus, as chairman of the delegation and P. John Robechek, M.D., Cleveland, as vice-chairman. **These nominations were ratified by the Council.**

Vacancies on AMA Councils and Committees

Forthcoming vacancies on AMA Councils and Committees were reviewed and the Council agreed to review the candidates for these positions.

Report on National Blue Shield Plans

A report by Dr. Budd on the January 22-24 meeting of the National Association of Blue Shield Plans was received for information.

AMA Meeting in Cincinnati

Dr. Hines discussed plans of the Cincinnati Academy of Medicine and the American Medical Association to promote attendance at the 1972 Clinical Meeting of the AMA in Cincinnati, November 26-29.

The Council advised that the Ohio State Medical Association will underwrite a hospitality function as the host state association to the extent of $5,000. Mr. Gillen was designated to assist with the arrangements.

OSMA Annual Meeting

Distinguished Service Citation

Dr. Charles Austin Doan, Columbus, was selected by the Council as the recipient of the Ohio State Medical Association Distinguished Service Citation for 1972.

Section Designation Discussed

Dr. Donald J. Vincent, Columbus, discussed the present title of the Section on Directors of Medical Education. It was agreed that further review of the role of the Ohio State Medical Association Commission on Education, and the relationship of the Section on Directors of Medical Education with the Commission is currently indicated.

Resolutions Filed

A resolution filed in place of a previous resolution by the Ross County Medical Society, and four resolutions from the Academy of Medicine of Cincinnati were presented to the Council for information.

Resolution to Amend OSMA Bylaws

The Council **approved** the following resolution to be submitted on its behalf to the House of Delegates for amending the Bylaws of the Ohio State Medical Association:

Resolution

WHEREAS, Chapter 1, Section 6, of the present Bylaws of the Ohio State Medical Association presently provides as follows:

> "Section 6. **Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of five years from the date of the filing in an appropriate court of

record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such five year period or on January 1, 1974 whichever date is later."

WHEREAS, It has come to the attention of the Council that said section imposes a hardship upon noncitizen members of the Association who are undertaking to acquire United States citizenship, because the minimum time to acquire citizenship is often closer to six years than five years from date of filing a declaration of intention, and

WHEREAS, Ohio State Medical Association policy has been strongly to encourage membership in this Association of noncitizen physicians who seek and acquire United States citizenship within the time required by law; therefore be it

RESOLVED, That the Council recommend to the House of Delegates that Chapter 1, Section 6, of the Bylaws be amended as follows:

"Section 6. **Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of six years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such six year period or on January 1, 1974 whichever date is later."

Question on Unit Rule

A communication from the Lake County Medical Society concerning the unit rule for councilor district delegations was presented to the Council for an opinion. The Council advised that Lake County Medical Society delegates may agree not to be bound by unit rule with the delegates of the Fifth District of the OSMA House of Delegates, in the absence of a prior agreement on their part to so be bound.

County Medical Society Constitutions and Bylaws

Adams County

The revised Constitution and Bylaws of the Adams County Medical Society **were approved,** contingent on the establishment of a percentage of attendance necessary for a quorum.

Coshocton County

The revised Constitution and Bylaws of the Coshocton County Medical Society **were approved** as presented.

Darke County

The revised Constitution and Bylaws of the Darke County Medical Society **were approved,** pending certification of adoption under the rules.

Delaware County

The revised Constitution and Bylaws of the Delaware County Medical Society **were approved** as presented.

Marion County

The revised Constitution and Bylaws of the Marion Academy of Medicine **were approved** as presented.

Committee Reports

Ad Hoc Committee on Health Care Delivery Systems

Dr. H. William Porterfield presented the minutes of the meeting of the Ad Hoc Committee on Health Care Delivery Systems held on January 22, 1972.

The Council then convened in executive session.

The minutes were re-referred to the committee under the provisions of Chapter 9, Section 8 of the OSMA Bylaws, along with the advice of the Council that the report is in contradiction with the Ad Hoc Committee on Health Care Delivery Systems minutes of September 8, 1971, which had been approved by the Council on October 2 and 3, 1971.

Ad Hoc Committee on Resolution No. 14-71

Continuing in executive session, the Council received the report of the February 9 meeting of the Ad Hoc Committee on Resolution No. 14-71 as presented by Dr. Fulton. The following definitions **were adopted,** modifying those approved by the Council at its meeting of October 2-3, 1971:

Closed Panel—(a) Refers to a predesignated group of patients who are to receive medical care; and/or (b) Refers to a predesignated group of physicians who are to deliver medical care to patients as mentioned in (a).

Prepaid — (a) Method of financing Health Insurance to pay for health care—as in Blue Cross and Blue Shield. (b) Refers to the payment of physicians prior to performance of services by those physicians and so differs from the fee-for-service type of payment previously endorsed by practicing physicians and OSMA.

Consumer Controlled — Refers to any medical organization which is dominated and controlled by nonphysicians rather than by physicians.

Group Practice — A practice carried on by two or more physicians who have organized for the purpose of delivering health care.

The Council adjourned its executive session and reconvened in regular session.

Commission on Medical Education

The minutes of the December 15, 1971 meeting of the Commission on Medical Education were presented by Mr. Edgar and **were accepted** for information.

The minutes of the January 26, 1972 meeting of the Commission on Medical Education were presented by Mr. Edgar.

Approval of the minutes included the approval of a revised survey on use of nonphysicians as assistants. The survey of OSMA members is to be conducted by Health Careers of Ohio, Inc.

Committee on Eye Care

The minutes of a meeting of the Committee on Eye Care, held January 12, 1972, were presented by Mr. Rader and **were approved.**

Joint Advisory Committee on Special Education

The minutes of the January 12, 1972 meeting of the Joint Advisory Committee on Special Education were presented by Mr. Clinger, for information only, since they will be considered by the Committee on School Health before being submitted to the Council for approval.

The Council **approved** the appointment of Dr. Arthur F. Ritchey, Cleveland, to the committee.

Committee on Maternal Health

The 1969 Annual Report on Maternal Mortality in Ohio was presented by Dr. A. J. Ruppersberg, Jr., chairman of the Committee on Maternal Health, and **was approved** and ordered published in *The Ohio State Medical Journal.*

Dr. Ruppersberg commented on current trends in maternal care and on the mission of his committee. He announced that the committee is currently scanning the possibility of expanding the maternal mortality study to include maternal morbidity as well.

The Council also **approved** the minutes of the meeting of the Committee on Maternal Health, held January 15 and 16, 1972, as presented by Mr. Gillen. Approval of the minutes included approval of a recommendation that the Ohio Public Health Council give consideration to investigating and expanding the number and types of gynecological cases that can safely be integrated in maternity units; of a recommendation that the Ohio Death Certificate be amended to include the Social Security number of the deceased; and of a list of causes of fetal death with the recommendation that it be printed on the reverse side of the certificate of stillbirth.

Subcommittee on Title XIX

The report of the January 19, 1972 meeting of the Subcommittee on Title XIX was presented by Mr. Gillen.

In accordance with the recommendations of the committee, the Council **approved** the draft of a letter from President Robechek to the Division of Medical Assistance of the Ohio Department of Public Welfare, outlining the Association's objections to a proposed billing form presently being considered for use in a "model" program being developed by Consultec for the department.

Also in accordance with the recommendations of the committee, the Council **approved** the text of a letter from the OSMA legal counsel to the legal counsel for the Ohio Department, outlining the Association's objections to a proposed "provider agreement" which has been suggested by the Welfare Department, and which is considered unacceptable by the Association and far beyond the requirements of federal law.

The report of the subcommittee **was approved.**

Committee on Private Practice

The minutes of the January 19, 1972 meeting of the Committee on Private Practice were presented by Dr. Lieber. The report **was approved** as presented, including approval of recommendations that (1) Dr. Robert E. Tschantz be nominated by the Ohio State Medical Association for appointment to the newly-established AMA Commission on Emergency Room Services; (2) the Association's policy in opposition to generic prescribing be reaffirmed and that the Ohio Director of Welfare be so advised; (3) vigorous opposition of the OSMA to Senate Bill 469, which would permit Hospital Service Associations to make con-

tract with and payments to hospital outpatient clinics for services provided in outpatient clinics, even if the clinics are not joined with a hospital.

OSMA-Ohio State Bar Association Liaison Committee

A report of the February 11 meeting of the OSMA-Ohio State Bar Association Liaison Committee was presented by Dr. Clarke. Dr. Clarke asked for the authority to appoint a subcommittee to work with representatives of the Bar Association to revise the Code of Cooperation for Physicians and Lawyers, developed by the OSMA and the OSBA in 1957, and specified that the new code include standards for interprofessional relationships. The request was granted.

He also requested approval of a subcommittee to formulate principles for the organization of arbitration panels by county bar associations and county medical societies. The Council **approved.** Also **approved** was his recommendation for educational seminars on a district basis to improve relationships between physicians and lawyers. The Council recommended that the liaison committee serve in arbitration between physicians and lawyers, when local resources are exhausted or do not exist.

Committee on Laboratory Medicine

A proposed pre-employment screening examination to detect the use of drugs was referred to the Committee on Laboratory Medicine for study and advice to the Council.

Committee on Membership and Planning

The staff was instructed to revise and modernize the booklet on OSMA services to members, under the aegis of the Committee on Membership and Planning.

Dr. Schultz discussed the consumer survey being conducted by the Membership and Planning Committee with the firm Ketchum, McLeod and Grove, Pittsburgh.

Ohio State Medical Board

Mr. William J. Lee, Administrator, Ohio State Medical Board, announced that 263 Doctors of Medicine passed the December examination for licensure. He indicated that there was a 500 percent increase in enforcement matters and a 200 percent increase in licensing matters in 1971 over 1970. He expressed the opinion that enforcement problems involving the handling of drugs were of increasing concern.

Medical Advances Institute

A review of the work of the Medical Advances Institute was presented by its President, Dr. James L. Henry.

Ohio Medical Indemnity, Inc.

Dr. Fulton, chairman of the OSMA-OMI Liaison Committee, presented a report of the committee.

Nominations for Board of Directors

The committee recommended that the following be nominated and elected to the OMI Board of Directors for the ensuing year: Ralph L. Abernathy, Dayton; Ben Arnoff, M.D., Columbus; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; Guerney H. Cole, Jr., Middletown; William R. Culbertson, M.D., Cincinnati; Donald W. Dewald, M.D., Mansfield; Paul N. Ivins, M.D., Hamilton; Paul A. Jones, M.D., Zanesville; Robert A. McLemore, M.D., Springfield; Usher B. Redmann, Toledo; Theodore T. Reed, Jr., Pomeroy; James G. Roberts, M.D., Akron; Frank D. Robinson, Canton; Frank L. Shively, Jr., M.D., Dayton; Robert N. Smith, M.D., Toledo; Wendell D. Stewart, Lima; Phillip W. Tefft, Columbus; M. M. Thompson, M.D., Toledo; Gordon M. Todd, M.D., Toledo; Charles G. Zegiob, M.D., Cleveland.

By official action, the Council **approved** the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting, including the election of directors placed in nomination by the Council at this meeting on February 12-13, 1972: Richard L. Fulton, M.D., Columbus, or Paul N. Ivins, M.D., Hamilton, or William M. Wells, M.D., Newark, or Mr. Hart F. Page, Columbus.

On behalf of the Council, the President was authorized to thank the retiring director for his past service.

Report on 1971 Business

Mr. Page reviewed the report of 1971 business which was presented orally at the January 26, 1972 meeting of the Board of Directors.

Utilization Review Proposal

The Council received a letter from Michael J. Ketchum to Hart F. Page, dated February 9, 1972, transmitting a utilization review proposal

(Continued on Page 377)



CALORIES / 1 Cup Prepared Soup*

Beef Broth	25	Vegetable	77
Consomme	33	Tomato	79
Chicken with Rice	49	Cream of Asparagus	80
Chicken Gumbo	55	Cream of Chicken	87
Chicken Noodle	62	Beef	99
Chicken Vegetable	68	Cream of Potato	105
Turkey Noodle	72	Cream of Mushroom	131
Vegetable Beef	75	Green Pea	131

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 536, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ..for every meal and, it's made by Campbell

the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences in their activity levels and estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

References. **1.** Editorial: Oral Contraceptives, Which Pill for Which Patient? Patient Care 3:90-115 (Feb.) 1969 and 4:135-145 (June 15) 1970. **2.** Greenblatt, R. B.: Progestational Agents in Clinical Practice, Med. Sci. *18*:37-49 (May) 1967. **3.** Kistner, R. W.: Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W.: The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H.: Clinical Evaluation of Side Effects of Current Oral Contraceptives, J. Reprod. Med. 6:50-55 (Feb.) 1971. **6.** Orr, G. W.: Oral Progestational Agents: Therapy and Complications, S. Dakota J. Med. *22*:11-17 (Jan.) 1969.

the Ovulen phase

Most women* with a **balanced hormone profile a normal menses** do best on a middle-of-the-road p that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts feminine appearance, healthy skin and hair. Vagin cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slig progestogen dominance. It has an excellent recor of patient acceptance.

Ovulen®

Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information, see following page.



the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg / ethinyl estradiol 50 mcg
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients
Both Ovulen and Demulen are available in 21- and 28-pill schedules

the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

Enovid-E®

Each tablet contains: norethynodrel 2.5 mg / mestranol 0.1 mg

Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.

for the 3 phases of Eve:

a family of O.C. products

Ovulen®

Each white tablet contains
ethynodiol diacetate 1 mg., mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 196
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

SEARLE Products of SEARLE & CO.
San Juan, Puerto Rico 00936

Enovid-E®

norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

SEARLE **Enovid-E®**

brand of norethynodrel with mestranol

Product of G. D. Searle & Co.
P.O. Box 5110, Chicago, Illinois 60680
Where "The Pill" Began

with a target date for implementation set for June, 1972.

The Council expressed the opinion that the proposal is unacceptable and strongly recommended that Medical Advances Institute call a meeting of all carriers representing Ohio at the AMA Conference on Efficient Use of Health Care Services, Chicago, January 14, 1972 in order to carry through commitments made during the conference.

Fee Freeze and Hold Harmless

Council discussed two developments, one being the Federal Price Commission regulation that a statement of information on fees be posted in physicians' offices and the other being the decision of Ohio Medical Indemnity, Inc. to "hold harmless" the subscriber when OMI payments under usual, customary and reasonable fee contracts are less than the physician's fee.

Council voted to have inserted in the next OSMAgram two printed statements for display in the physician's office, one statement being in compliance with the Federal Price Commission regulation and the second statement being to inform patients that, when third party payments are less than the physician's fee, the patient is not relieved of his responsibility to the physician for the unpaid difference.

Ohio Medical Indemnity, Inc. was requested to advise the Council of OMI's concept of the "hold harmless" program and its intent with regard to the implementation thereof.

Council directed that OMI be asked to prepare for publication in *The Ohio State Medical Journal* a comprehensive article on "Hold Harmless."

Legislation

Federal Legislation

Mr. Edgar presented an informal report on Federal legislation.

State Legislation

A report on state legislation was presented by Mr. Rader.

The following bills were reviewed and received opinions of the Council:

S.B. 176 (Shaw)—Licensing of Psychologists. Approved an amendment providing that psychotherapy by a psychologist must be in collaboration with a physician. Action: **Vigorously oppose unless amendment is adopted.**

S.B. 259 (Ocasek)—Licensing of psychologists. Action: **Oppose.**

S.B. 346 (Mottl)—Licensing of physicians' assistants. Action: **Actively oppose.**

S.B. 469 (Meshel)—Outpatient services by Blue Cross. Action: **Vigorous opposition.**

H.B. 621 (Mayfield) — Commitment Law Amendments. Action: **Referred to Committee on Mental Health for study.**

H.B. 756 (J. Sweeney)—Commitment Law Amendments. Action: **Referred to Committee on Mental Health for study.**

H.B. 808 (Cruze)—Identical with S.B. 346. Action: **Actively oppose.**

H.B. 994 (J. Thompson)—Sickle cell anemia test during pre-marital blood test. Action: **Referred to Committee on Laboratory Medicine for study.**

H.B. 1004 (James)—Sickle cell anemia test for school children. Action: **Referred to Committee on School Health for study.**

H.B. 1024 (James)—Requires director of health to assist in research, education, and treatment programs on sickle cell anemia. Action: **Referred to the Committee on Laboratory Medicine for study.**

The legal counsel of the Association was instructed to prepare legislation to assist in protecting the public from podiatrists who work outside the scope of their training.

Health Lines

The Council authorized Mr. Edgar to obtain additional information on the "Health Lines" program and the possibility of making it available throughout Ohio.

Environment Conference

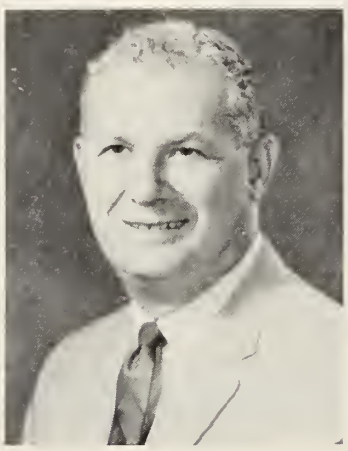
Dr. Roland Kennedy, Toledo and Mr. Rader were authorized to represent the OSMA at a followup conference on ecology, environment and pollution, April 13-14, Detroit, Michigan.

The next meeting of the Council was set for April 15-16, 1972 at the headquarters office.

ATTEST: Hart F. Page
Executive Director

Steubenville Physician Is Named to the State Medical Board

Dr. Sanford Press, of Steubenville, recently was named by Governor John J. Gilligan to the State Medical Board of Ohio, the agency charged with the responsibility of licensing physicians and other practitioners and enforcing the law as it applies to the healing arts in Ohio.



Sanford Press, M.D.

Dr. Press is a general practitioner in Steubenville with special interest in the field of obstetrics and gynecology. He succeeds Dr. Frederick T. Merchant, of Marion, whose term of office expired this year.

In addition to his practice, Dr. Press has shown outstanding interest in medical organization work as well as in community affairs.

For six years he has been a member of The Council of the Ohio State Medical Association, representing the Seventh Councilor District. Also among State Association activities, he has served on the Committee on Private Practice, the Joint Committee on Sports Medicine, and the Awards Committee which selects outstanding exhibits at the OSMA Annual Meeting for special recognition.

He has held several offices in the Ohio Academy of Family Physicians — as speaker of the Academy's House of Delegates, as director for the Seventh District, and as chairman of the Academy's Program Committee. He also is a past president of the Fort Steuben Academy of Medicine, an organization dedicated to the promotion of continuing education for Steubenville area physicians.

Among community activities, he is a member and past president of the Lions Club, a member of the Elks Lodge, and a member of several Masonic bodies including the Shrine. He is active in his Synagogue and has held the position of president. He has been team physician for the local high school, and served for many years as physician for the Jefferson County Home for the Aged. He is also an authorized examiner for railroad and aviation personnel.

His practice in Steubenville has been continuous since 1940 with the exception of the war years. In 1942 he joined the U. S. Air Force and served as flight surgeon, serving in the China-India-Burma Theater where he attained the rank of major.

Dr. and Mrs. Press are the parents of two daughters.

Dr. Frederick Merchant who is retiring from the Board after 14 years of service, has made outstanding contributions on the local, State, and national levels. He is a past president of the Marion County Medical Society and a former member of The Council of the Ohio State Medical Association. Other activities in his community and on the state level are numerous.

Dr. Merchant has long been a member of the Federation of State Medical Boards of the United States and in 1970 was named its president. In the April, 1970 issue of the *Bulletin* of the Federation, he was praised in a feature article for his pioneer efforts in behalf of the Flex examinations which have become a key in licensure throughout the country.

The eight-member Medical Board held its annual election recently and named Peter Lancione, M.D., of Bellaire, as president. (See March issue of *The Journal,* page 305.) John D. Brumbaugh, M.D., Akron, was named vice-president; Henry A. Crawford, M.D., Cleveland, treasurer; and Henry G. Cramblett, M.D., Columbus, secretary.

Other members of the Board are Ralph K. Ramsayer, M.D., Canton; Anthony Ruppersberg, Jr., M.D., Columbus; and James O. Watson, D.O., Columbus. William J. Lee, attorney, is the Board's administrator, or chief executive officer.

State Medical Board of Ohio



This photo of the State Medical Board was taken at its meeting on February 24. Front row, from left are Henry A. Crawford, M.D., treasurer; John D. Brumbaugh, M.D., vice-president; Peter Lancione, M.D., president; and Henry G. Cramblett, M.D., secretary. Standing, from left, are Frederick Merchant, M.D., Anthony Ruppersberg, M.D., James O. Watson, D.O., and Ralph K. Ramsayer, M.D., Dr. Press succeeds Dr. Merchant on the Board, William J. Lee, administrator is not shown.

Discussion of E.N.T. Case of the Month

(continued from p. 366)

The diagnosis was squamous carcinoma of the nasopharynx.

In a complete evaluation of the nasopharynx in any adult with unilateral serous otitis media, it is important to examine the opening of the eustachian tube. Although the usual findings will be a relatively benign problem, such as an upper respiratory infection with edema of the eustachian tube, allergy, or sinusitis with purulent drainage over the eustachian tube, carcinoma must always be ruled out.

Carcinomas arising in the nasopharynx usually occur in the region of the eustachian tube orifice and frequently may impair the ventilation of the middle ear causing the air in this space to be absorbed and replaced with a serous transudate.

In this patient, the presence of a firm nontender node in the posterior triangle of the neck makes one highly suspicious of a nasopharyngeal tumor, since 50 percent of patients with these lesions will have metastatic nodes in this location.

The primary treatment for this lesion is radiation therapy.

Candidate for Office of President-Elect



Oscar W. Clarke, M.D.

IN ACCORDANCE WITH Section 3 of Chapter 5 of the OSMA Bylaws, the following nomination of a candidate for the office of President-Elect of the Ohio State Medical Association has been filed with the Executive Director 60 days prior to the meeting of the House of Delegates at which the election is to take place:

Gallia County Medical Society

Gallipolis, Ohio
February 1, 1972

Mr. Hart F. Page
Executive Director
Ohio State Medical Association
17 South High Street
Columbus, Ohio 43215

Dear Mr. Page,

By constitutional privilege, we are pleased to nominate Oscar W. Clarke, M.D., the Ninth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Doctor Oscar W. Clarke is qualified by membership in good standing in the Gallia County Medical Society, the Ohio State Medical Association, and the American Medical Association.

Respectfully submitted,

Donald E. O'Rourke, M.D.
President

Thomas W. Morgan, M.D.
Delegate

OSCAR W. CLARKE, M.D.

Curriculum Vitae

OFFICE: Holzer Medical Center, 4th & Sycamore Street, Gallipolis, Ohio 45631

RESIDENCE: Spruce Knoll, Gallipolis, Ohio 45631

PRACTICE: Internal Medicine
Diplomate of American Board of Internal Medicine

BIRTHPLACE: Petersburg, Virginia — January 29, 1919

EDUCATION:

- B.S. 1941—Randolph Macon College, Ashland, Virginia
- M.D. 1944—Medical College of Virginia
- Internship—Boston City Hospital, Boston, Massachusetts—1944-1945
- Residency Training—Medical College of Virginia—1945-1946, 1948-1949
- National Heart Institute Fellow — Medical College of Virginia—1949-1950

MILITARY SERVICE:

- United States Air Force—Chief of Medicine 317th Station Hospital, Wiesbaden, Germany

HOSPITAL APPOINTMENTS:

- Regular Staff and Chief of Internal Medicine—Medical Center Hospital, Gallipolis, Ohio—1963-1968
- Regular Staff Holzer Medical Center Hospital
- Vice President of Staff Holzer Medical Center Hospital
- Board of Trustees Holzer Medical Center Hospital

PROFESSIONAL SOCIETY MEMBERSHIPS:

- Gallia County Medical Society — President 1953
- Ohio State Medical Association
- American Medical Association
- Fellow American College of Physicians
- Fellow Royal Society of Medicine
- American Heart Association
- Central Ohio Heart Association — Trustee 1956-1969
- Gallia County Heart Branch—President 1955-1964
- American Society of Internal Medicine
- Ohio Society of Internal Medicine — Vice President 1959-1960 and Board of Trustees 1957-1960
- American Federation for Clinical Research
- American Association for Advancement of Science

OHIO STATE MEDICAL ASSOCIATION ACTIVITIES:

Councilor Ninth District—1966-1972
Chairman of OSMA Advisory Committee to Woman's Auxiliary of OSMA — 1969-1971
Chairman of OSMA Scientific Exhibition Evaluation Committee—1969-1971
Chairman of OSMA Auditing and Appropriations Committee—1971-1972
Chairman of OSMA Liaison Committee with the Ohio State Bar Association
Trustee Medical Advances Institute
Member OSMA Hospital Relations Committee
Member OSMA Workmen's Compensation Committee—1960-1966
Member OSMA Membership and Planning Committee
Member OSMA Joint Coordinating Health Planning Committee with Ohio State Hospital Association
OSMA Representative to Professional Relations Committee of Ohio State Hospital Association—1969-1970
OSMA Alternate Delegate to American Medical Association—1970-1971
OSMA Delegate to American Medical Association—1972-1973

CIVIC AND OTHER ORGANIZATIONS:

President Gallipolis City Board of Health
President Rotary Club of Gallipolis, Ohio—1953-1954
President Tri-County Community Concert Association—1957-1959
Vice-President Tri-State Regional Council Boy Scouts of America—1957
Trustee Medical Memorial Foundation—1963-1969
Trustee Holzer Medical Foundation
Trustee Gallia County Historical Society
Board of Directors Community Improvement Corporation
Gallipolis City Planning Commission—1957
Ohio State Historical Society
Ohio State Medical Historical Society
American Association for the History of Medicine
French Art Colony
Huntington Galleries
Sierra Club
The Wilderness Society
Audubon Society

FRATERNAL ORGANIZATIONS:

Alpha Omega Alpha (Honorary)
Sigma Zeta (Honorary)
Chi Beta Phi (Scientific)
Phi Chi (Medical)

FAMILY:

Married to the former Susan Frances King, of Kalispell, Montana
Children:
Susan—Junior, Denison University
Elizabeth—Married
Jenny—Sophomore, Gallia Academy
One Grandson—Jimmy

RELIGIOUS AFFILIATION:

Presiding Elder First United Presbyterian Church of Gallipolis, Ohio

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Ohio Medical Golfers to Meet on Marion Greens

The annual tournament of the Ohio State Medical Golfers Association will be held at the Marion Country Club, Marion, on Tuesday, June 20.

This is an 18-hole event and cups will be going to the player with the low gross and low net, as well as to the low gross and low net in the different age categories. There will be door prizes. Luncheon and dinner will be served at the club.

All Ohio physicians are invited to participate in this tournament, regardless of whether or not they have participated in the past.

For additional details, contact the tournament chairman, C. J. Shamess, M.D., 74 Wood Street, Mansfield 44903.

The 32nd Annual Congress on Occupational Health sponsored by the American Medical Association will be held at the Drake Hotel in Chicago, September 11-12. For details contact Henry F. Howe, M.D., Secretary, Council on Occupational Health, 535 N. Dearborn Street, Chicago, Illinois 60610.

HOUSE OF DELEGATES

SUNDAY, MAY 7, 1972

7:00 P.M.

Councilor District Caucus Meetings
Terrace Hilton Hotel

District	Councilor	Room Number
First	Paul N. Ivins	1926
Second	James G. Tye	1914
Third	Dwight L. Becker	1918
Fourth	George N. Bates	1908
Fifth	David Fishman	Skyline Ballroom
Sixth	Maurice F. Lieber	1905
Seventh	Sanford Press	1801
Eighth	William M. Wells	1802
Ninth	Oscar W. Clarke	1835
Tenth	James C. McLarnan	1909
Eleventh	Robert G. Thomas	1922

MONDAY, MAY 8, 1972

7:30 A.M.

Breakfast, Delegates, Alternates, OSMA Council and Official Guests
Bronze Rooms A and B, Second Floor
Stouffer's Cincinnati Inn

7:30-9:00 A.M.

Registration for OSMA House of Delegates
Upper Lobby, Second Floor
Cincinnati Exposition Center

9:00 A.M.

OSMA House of Delegates
First Business Session
Room 209, Second Floor
Cincinnati Exposition Center

12:00 Noon

Buffet Luncheon for Delegates, Alternates, OSMA Council and Official Guests
Bronze Rooms A and B, Second Floor
Stouffer's Cincinnati Inn

BUSINESS AGENDA

First Session, House of Delegates
9:00 A.M.

Call to Order by the President—P. John Robechek, M.D., Cleveland.

Invocation—Rev. Ernest N. Bigelow, Cincinnati.

Welcome: Milton W. Gwinner, M.D., President, Academy of Medicine of Cincinnati.

Address: C. A. Hoffman, M.D., President-Elect, American Medical Association.

Report of the Committee on Credentials.

Consideration of the Minutes of the last Annual Meeting (July 1971 issue of The Journal).

Introduction of honored guests.

Report by the President of the Woman's Auxiliary—Mrs. Russell L. Wiessinger, Lima.

Recognition of Defiance County AMA-ERF Contribution to Paul E. Brose, M.D., Defiance County Delegate—Philip B. Hardymon, M.D., Chairman, Ohio Committee on AMA-ERF.

Presentation of AMA-ERF checks to representatives of Ohio medical schools—Philip B. Hardymon, M.D., Chairman, Ohio Committee on AMA-ERF. University of Cincinnati College of Medicine; Case Western Reserve University School of Medicine; Ohio State University College of Medicine and the Medical College of Ohio at Toledo.

Presentation of plaques honoring physicians serving with Project Vietnam—P. John Robechek, M.D., Cleveland, OSMA President.

Presentation of plaques to Past Councilors and retiring AMA Delegates and Alternates; Chairmen and members of Standing Committees and Chairmen of Special Committees.

Presentation of Distinguished Service Citations.

Presentation of Special Award.

Announcement of appointments to the Reference Committees by the President: Credentials; President's Address; Resolutions; and Tellers and Judges of Election.

Election of Committee on Nomination:
(Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Thursday, May 11, 9:00 a.m., its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Tenth District shall serve as chairman). The report of the Nominations Committee with respect to all offices except President-elect shall be posted at registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address:
P. John Robechek, M.D., Cleveland.

Introduction of Presidents of other State Societies.

Introduction of Resolutions:
(Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Thursday morning session before any action can be taken. All resolutions not submitted in advance of the 60-day deadline must be typewritten and submitted in triplicate.)

Election of Honorary Member to the Ohio State Medical Association.

Miscellaneous Business.

MONDAY, MAY 8, 1972

Meeting of Reference Committees

(All Reference Committee Meetings held in Cincinnati Exposition Center)
1:30 P.M.

Resolutions Committee No. 1—Room 211
Resolutions Committee No. 2—Room 213
Resolutions Committee No. 3—Room 217
Resolutions Committee No. 4—Room 225
President's Address—Room 221
Committee on Nominations—Room 223

REFERENCE COMMITTEE APPOINTMENTS

PRESIDENT'S ADDRESS

Chairman: Richard L. Fulton, M.D.
(Franklin County, District 10)
Kenneth W. Clement, M.D.
(Cuyahoga County, District 5)
Robert P. Johnson, M.D.
(Butler County, District 1)
Emil Meckstroth, M.D.
(Erie County, District 11)

TELLERS AND JUDGES OF ELECTION

Chairman: E. Peter Coppedge Jr., M.D.
(Cuyahoga County, District 5)
Philip T. Doughten, M.D.
(Tuscarawas County, District 7)
John E. Albers, M.D.
(Hamilton County, District 1)
F. Miles Flickinger, M.D.
(Allen County, District 3)
A. Burton Payne, M.D.
(Lawrence County, District 9)
Philip H. Taylor, M.D.
(Franklin County, District 10)

CREDENTIALS OF DELEGATES

Chairman: H. William Porterfield, M.D.
(Franklin County, District 10)
Marvin McClellan, M.D.
(Hamilton County, District 1)
Thomas F. Moriarty, M.D.
(Henry County, District 4)
Robert Elliott, M.D.
(Hardin County, District 3)
L. J. DeFreest, M.D.
(Summit County, District 6)

RESOLUTIONS COMMITTEE NO. 1

Chairman: Robert R. Clark, M.D.
(Summit County, District 6)
John J. Gaughan, M.D.
(Cuyahoga County, District 5)
William J. Lewis, M.D.
(Montgomery County, District 2)
Stephen P. Hogg, M.D.
(Hamilton County, District 1)
John C. Smithson, M.D.
(Hancock County, District 3)
Harry C. Mack, M.D.
(Lucas County, District 4)
Robert Rinderknecht, M.D.
(Tuscarawas County, District 7)

(Continued on Next Page)

RESO. COMMITTEE NO. 1—(Contd.)

Walter B. Devine, M.D.
(Muskingum County, District 8)
Thomas W. Morgan, M.D.
(Gallia County, District 9)
John N. Meagher, M.D.
(Franklin County, District 10)
James T. Stephens, M.D.
(Lorain County, District 11)

RESOLUTIONS COMMITTEE NO. 2

Chairman: William V. Trowbridge, M.D.
(Cuyahoga County, District 5)
Roland A. Gandy, Jr., M.D.
(Lucas County, District 4)
Foster J. Boyd, M.D.
(Clinton County, District 1)
Jerry L. Hammon, M.D.
(Miami County, District 2)
Paul E. Lyon, M.D.
(Marion County, District 3)
C. Edward Pichette, M.D.
(Mahoning County, District 6)
Paul Mastros, M.D.
(Jefferson County, District 7)
Gregory B. Krivchenia, M.D.
(Washington County, District 8)
Harry Nenni, M.D.
(Lawrence County, District 9)
Ben E. Jacoby, M.D.
(Franklin County, District 10)
A. Burney Huff, M.D.
(Wayne County, District 11)

RESOLUTIONS COMMITTEE NO. 3

Chairman: Jasper M. Hedges, M.D.
(Pickaway County, District 10)
Milton W. Gwinner, M.D.
(Hamilton County, District 1)
George J. Schroer, M.D.
(Shelby County, District 2)

RESO. COMMITTEE NO. 3—(Contd.)

John A. Glorioso, M.D.
(Allen County, District 3)
Benjamin H. Reed, Jr., M.D.
(Fulton County, District 4)
Clarence L. Huggins, M.D.
(Cuyahoga County, District 5)
Edward E. Grable, M.D.
(Stark County, District 6)
Robert R. Johnson, M.D.
(Coshocton County, District 7)
James Toland, M.D.
(Guernsey County, District 8)
John W. Zimmerly, M.D.
(Jackson County, District 9)
Robert W. Jones, M.D.
(Richland County, District 11)

RESOLUTIONS COMMITTEE NO. 4

Chairman: Homer A. Anderson, M.D.
(Franklin County, District 10)
Thomas E. Fox, M.D.
(Warren County, District 1)
William G. Cassel, M.D.
(Montgomery County, District 2)
Robert S. Oyer, M.D.
(Auglaize County, District 3)
Cyrus R. Wood, M.D.
(Ottawa County, District 4)
Wesley J. Pignolet, M.D.
(Lake County, District 5)
Rocco Antenucci, M.D.
(Summit County, District 6)
German Ortiz, M.D.
(Belmont County, District 7)
Lawrence A. Miller, M.D.
(Licking County, District 8)
Walter A. Daniel, M.D.
(Seneca County, District 9)
Richard W. Avery, M.D.
(Medina County, District 11)

(See Page 389 for House of Delegates' Final Session Agenda)

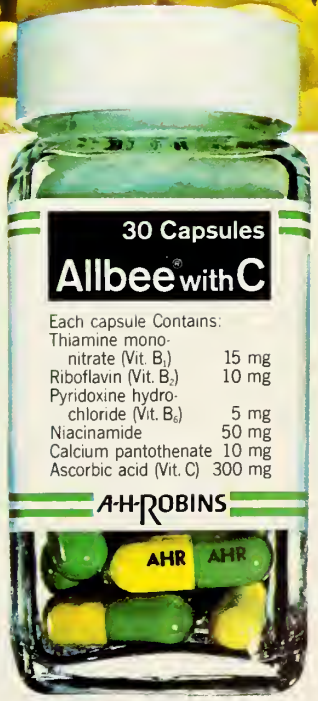


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As a source of ascorbic acid, the lemon really hits a high C (50 mg.). But your patient would still have to eat 180 lemons every month—6 a day—to get a therapeutic dose. And as the calypso singer puts it, "one hundred eighty lemons is impossible to eat." Fortunately, a bottle of 30 Allbee with C capsules (taken one capsule daily) supplies as much Vitamin C as all those lemons, plus full therapeutic amounts of the B-complex vitamins. For example, as much B_6 as two pounds of corn. Allbee with C is no lemon! This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

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"the Donnatal® Effect"

	each tablet, capsule or 5 cc. teaspoonful of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

Brief summary. Side effects: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. Contraindicated in patients with acute glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

140/90 is normal blood pressure... or is it?

An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

Study Findings. Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"[1]—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

Other Studies. Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

Another Point of View. Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."



Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

MSD
MERCK SHARP & DOHME

25- and 50-mg tablets

HydroDIURIL®
(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Kannel, William B., *et al.*: "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Consultant, Jan. 1971.

25- and 50-mg tablets

HydroDIURIL®

(Hydrochlorothiazide|MSD)

Therapy to Start With

Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

PRECAUTIONS: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Hypochloremic alkalosis occurs infrequently and is rarely severe. In severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur if dietary salt is unduly restricted, especially during hot weather.

Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics.

Pathological changes in the parathyroid glands with hypercalcemia and hypophosphatemia have been seen in a few patients on prolonged thiazide therapy. The effect of discontinuing thiazide therapy on serum calcium and phosphorus levels may be helpful in assessing the need for parathyroid surgery in such patients. Parathyroidectomy has elicited subjective clinical improvement in most patients, but has no effect on hypertension. Thiazide therapy may be resumed after surgery.

Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. May affect insulin requirements in diabetics; may induce hyperglycemia and glycosuria in latent diabetics.

ADVERSE REACTIONS: Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, cholestasis, and pericholangiolitic hepatitis. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, transient blurred vision, sialadenitis, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have linked thiazides to pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. When adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn.

For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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HOUSE OF DELEGATES

Final Session
THURSDAY, MAY 11

7:30 A.M.

Breakfast, Delegates, Alternates, OSMA Council and Official Guests
Bronze Rooms A & B, Second Floor
Stouffer's Cincinnati Inn

7:30-9:00 A.M.

Registration for OSMA House of Delegates
Upper Lobby, Second Floor
Cincinnati Exposition Center

9:00 A.M.

OSMA House of Delegates
Final Business Session
Room 209, Second Floor
Cincinnati Exposition Center

BUSINESS AGENDA

Final Session, House of Delegates
9:00 A.M.

Introduction of Guests.

Report of Committee on Credentials.

Election of President-Elect.

Report of Committee on Nominations and election of other officers.

(a) Nominations for The Council.

(Members of the Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years).

First District—(Incumbent, Paul N. Ivins, M.D., Hamilton) Note: Ineligible for re-election having served the maximum time on The Council as provided in the Constitution and Bylaws.

Third District—(Incumbent, Dwight L. Becker, M.D., Lima).

Fifth District—(Incumbent, David Fishman, M.D., Cleveland).

Seventh District—(Incumbent, Sanford Press, M.D., Steubenville). Note: Ineligible for re-election having served the maximum time on The Council as provided in the Constitution and Bylaws.

Ninth District — (Incumbent, Oscar W. Clarke, M.D., Gallipolis).

Eleventh District — (Incumbent Robert G. Thomas, M.D., Elyria).

(b) Election of Delegates and Alternates to the American Medical Association — 4 Delegates and 4 Alternates to be elected each for a two-year term starting January 1, 1973 in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1972, their terms expiring December 31, 1972.

Delegates
(Listed Alphabetically)
Richard L. Meiling, M.D., Columbus
Lawrence C. Meredith, M.D., Oberlin
Robert N. Smith, M.D., Toledo
Robert E. Tschantz, M.D., Canton

Alternates
(Listed Alphabetically)
Dwight L. Becker, M.D., Lima
David Fishman, M.D., Cleveland
Robert P. Johnson, M.D., Middletown
H. William Porterfield, M.D., Columbus

All nominees for the office of AMA Delegate and AMA Alternate shall run at large.

Election of Delegates and Alternates of the AMA shall be governed by Section 6, Chapter 5 of the OSMA Constitution and Bylaws as revised by the House of Delegates in May, 1971.

Reports of Reference Committees.

President's Address

Resolutions Committee No. 1

Resolutions Committee No. 2

Resolutions Committee No. 3

Resolutions Committee No. 4

Miscellaneous Business

Installation of Officers for 1972-73.

Announcement of Standing Committee Appointments by the newly installed President and action thereon by House of Delegates.

Unfinished Business.

Adjournment.

MEMBERS OF THE 1972 HOUSE OF DELEGATES

Listed in the following columns are Delegates and Alternate Delegates to the Ohio State Medical Association House of Delegates, as reported from each county to represent their respective County Medical Societies at the 1972 OSMA Annual Meeting, May 8-11. All business sessions of the House of Delegates will be held at the Cincinnati Exposition Center.

COUNTIES	Delegates	Alternates
FIRST DISTRICT		
ADAMS	Francis L. Stevens	William J. Lundy
BROWN	John R. Donohoo	Charles W. Hannah
BUTLER	Robert P. Johnson	John C. Gillen
	James M. Smith	James F. Stewart
CLERMONT	Carl A. Minning	Carl M. Sedacca
CLINTON	Foster J. Boyd	Mary Ranz Boyd
HAMILTON	Ambrose H. Clement	John E. Albers
	Frank P. Cleveland	Donald E. Brinkman
	Joseph G. Crotty	Frederick Brockmeier
	William R. Culbertson	Eugene J. Burns
	Milton W. Gwinner	Charles D. Feuss, Jr.
	Robert S. Heidt	George D. J. Griffin
	Harry K. Hines	H. Glenn Overley
	Stephen P. Hogg	Eli Rubenstein
	Elmer R. Maurer	Harold S. Schiro
	Marvin McClellan	William J. Schrimpf
	Glenn W. Pfister	Calvin F. Warner
	Clyde S. Roof	
	Albert E. Thielen	
	Andrew J. Weiss	
HIGHLAND		
WARREN	Thomas E. Fox	James H. Arnold
		Orville L. Layman
SECOND DISTRICT		
CHAMPAIGN	Isador Miller	Theodore E. Richards
CLARK	Henry A. Diederichs	Dale E. French
	Ernest H. Winterhoff	John W. Rechsteiner
DARKE	Delbert Blickenstaff	V. Ray Boli
GREENE	Roger C. Henderson	Paul C. Vernier
MIAMI	Jerry L. Hammon	A. Robert Davies
MONTGOMERY	William G. Cassel	Robert L. Hoffman
	A. J. Gabriele	Konrad Kircher
	William J. Lewis	Samuel A. Laneve
	Don E. Sando	John H. Taylor
	Benjamin Schuster	John R. Whitaker, Jr.
PREBLE	Chester J. Brian	Everett P. Trittschuh
SHELBY	George J. Schroer	
THIRD DISTRICT		
ALLEN	Thomas L. Edwards	F. Miles Flickinger
	John A. Glorioso	R. L. Holladay
AUGLAIZE	Robert S. Oyer	Elizabeth Kuffner
CRAWFORD	Horace B. Newhard	Darrel D. Bibler
HANCOCK	John C. Smithson	Chester L. Samuelson
HARDIN	Robert B. Elliott	Jay E. Pfeiffer
LOGAN	Gerald Munn	James Steiner
MARION	Paul E. Lyon	Thomas Quilter
MERCER	George H. McIlroy	James J. Otis
SENECA	Walter A. Daniel	
VAN WERT	A. C. Diller	William L. Iler
WYANDOT	K. K. Solacoff	Herschel A. Rhodes

COUNTIES	Delegates	Alternates
FOURTH DISTRICT		
DEFIANCE	Paul E. Brose	Nicolas E. Balmoria
FULTON	Benjamin H. Reed, Jr.	William J. Neal
HENRY	Thomas F. Moriarty	Reynaldo C. Soriano
LUCAS	Charles D. Ford	William G. Henry
	Roland A. Gandy	Theron L. Hopple
	Bernard L. Huffman	Michael B. James
	Harry C. Mack	Peter A. Overstreet
	Frederick P. Osgood	R. P. Whitehead
	Howard E. Smith	
OTTAWA	Cyrus R. Wood	John F. Bodie
PAULDING	Doyt E. Farling	Paul Ward
PUTNAM	James B. Overmier	John R. Brown
SANDUSKY		
WILLIAMS	John E. Moats	Robert W. Dilworth
WOOD	William H. Roberts	Clarence B. Nyce
FIFTH DISTRICT		
ASHTABULA	S. A. Burroughs	J. G. Macaulay
CUYAHOGA	James O. Barr	Luther O. Baumgardner
	Joseph L. Bilton	Theodore J. Castele
	Matthew R. Biscotti	John E. Coletta
	William F. Boukalik	Christopher Colombi
	John H. Budd	Peter E. Coppedge, Jr.
	Kenneth W. Clement	Arthur F. D'Alessandro
	Henry A. Crawford	James P. Farmer
	Nicholas G. DePiero	Eugene A. Ferreri
	John J. Gaughan	Albert J. Hart
	Clarence L. Huggins	Herman K. Hellerstein
	Roscoe J. Kennedy	Robert E. Hermann
	John A. Kmieck	Robert J. Izant, Jr.
	Vincent T. LaMaida	Steven Kovacs
	George P. Leicht	Leonard L. Lovshin
	Hermann Menges, Jr.	Pierce H. Mullally
	James R. O'Malley	Thomas H. Redding
	George W. Petznick	Robert P. Riley
	John H. Sanders	Leo H. Simoson
	A. Benedict Schneider	Timothy L. Stephens
	Frederick T. Suppes	Warner W. Tuckerman
	William V. Trowbridge	Leo Walzer
	Howard VanOrdstrand	Elden C. Weckesser
	Julius Wolkin	Ralph G. Wieland, Jr.
GEAUGA	Alton W. Behm	Arturo J. Dimaculangan
LAKE	Carl G. Madsen, Jr.	Edward D. Hudgens
	Wesley J. Pignolet	Harry A. Killian
SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	Leonard S. Pritchard
MAHONING	John C. Melnick	Rashid A. Abdu
	Felix A. Pesa	J. James Anderson
	Charles E. Pichette	Louis Bloomberg
	Jack Schreiber	Loren J. Zehr
PORTAGE	John F. Fulton	Rogelio G. Marcial
STARK	William D. Baker	Edward Joel Davis
	William B. Epps	Frank O. Goodnough
	E. E. Grable	James C. Hays
	Wm. A. White, Jr.	Christopher M. King
SUMMIT	Rocco Antenucci	Richard H. Champion
	Robert R. Clark	John A. Karnoupakis
	Lynn J. DeFreest	Joseph L. Kloss
	Wm. J. Holloway	Donald L. Springer
	John C. Johns	
	Thomas F. Ulrich	
TRUMBULL	Joseph L. Logan	George Mokris
	Robert J. Paul	Jerome J. Stanislaw
SEVENTH DISTRICT		
BELMONT	German Ortiz	Luis A. Vasquez
CARROLL	Samuel L. Weir	Carl A. Lincke
COSHOCTON	Robert R. Johnson	Norman L. Wright
HARRISON	Elias Freeman	Janis Trupovnieks
JEFFERSON	Paul Mastros	Francis A. Sunseri
MONROE	Byron Gillespie	
TUSCARAWAS	Robert Rinderknecht	Philip T. Doughten
		Robert L. Gerber

(Continued on Next Page)

Members of the House of Delegates (Contd.)

COUNTIES	Delegates	Alternates
EIGHTH DISTRICT		
ATHENS	Charles S. Baldwin	Leland P. Randles
FAIRFIELD	Richard E. Hartle	Donald B. Nichols
GUERNSEY	James A. L. Toland	Robert A. Ringer
LICKING	Lawrence A. Miller	Donald G. Jones
MORGAN	Austin A. Coulson	Henry Bachman
MUSKINGUM	Walter B. Devine	Carl E. Spragg
NOBLE	Edward G. Ditch	Frederick M. Cox
PERRY	Ralph E. Herendeen, Jr.	George C. Tedrow
WASHINGTON	Gregory B. Krivchenia	Mary L. Whitacre
NINTH DISTRICT		
GALLIA	Thomas W. Morgan	Arnold J. Sattler
HOCKING		
JACKSON	John W. Zimmerly	Carl J. Greever
LAWRENCE	Harry Nenni	A. Burton Payne
MEIGS	Roger P. Daniels	
PIKE	A. M. Shrader	Mack E. Moore
SCIOTO	James P. McAfee	Carter L. Pitcher
VINTON		
TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	A. R. Callander
FAYETTE	Robert A. Heiny	T. J. Hancock
FRANKLIN	Homer A. Anderson	Drew J. Arnold
	Michael A. Anthony	Paul M. DeMerit
	Joseph A. Bonta	Keith DeVoe, Jr.
	Ben E. Jacoby	James C. Good
	John N. Meagher	Walter M. Haynes, Jr.
	Jack W. Miles	Thomas M. Hughes
	H. William Porterfield	Charles W. Pavey
	Mark L. Saylor	Philip H. Taylor
	Donald W. Traphagen	James H. Williams
		Thomas B. Williard
KNOX	Henry T. Lapp	Charles E. Cassaday
MADISON	Sol Maggied	Jack M. Grant
MORROW	Joseph P. Ingmire	David James Hickson
PICKAWAY	Jasper M. Hedges	Emily E. Lutz
ROSS	Joseph S. McKell	Richard L. Counts
UNION	Paul R. Zaugg	Walter R. Burt
ELEVENTH DISTRICT		
ASHLAND	Jon H. Cooperrider	Charles H. Warne
ERIE	Emil J. Meckstroth	S. Baird Pfahl, Jr.
HOLMES	Adam J. Earney	Luther W. High
HURON	William R. Graham	Earl R. McLoney
LORAIN	Charles G. Adams	John N. Bartone
	Henry E. Kleinhenz	Harold E. McDonald
	James T. Stephens	William H. Miller
MEDINA	Richard W. Avery	William G. Halley
RICHLAND	Robert W. Jones	Richard B. Belt
	Harold F. Mills	Hall S. Wiedemer
WAYNE	A. Burney Huff	Robert E. Reiheld

OFFICERS

President ..... P. John Robechek
President-Elect ..... William R. Schultz
Past President ..... Richard L. Fulton
Treasurer ..... James L. Henry

COUNCILORS

First District ..... Paul N. Ivins
Second District ..... James G. Tye
Third District ..... Dwight L. Becker
Fourth District ..... George N. Bates
Fifth District ..... David Fishman
Sixth District ..... Maurice F. Lieber
Seventh District ..... Sanford Press
Eighth District ..... William M. Wells
Ninth District ..... Oscar W. Clarke
Tenth District ..... James C. McLarnan
Eleventh District ..... Robert G. Thomas

Resolutions Submitted for Consideration At the 1972 Annual Meeting

IN THE FOLLOWING COLUMNS are texts of several resolutions and titles of others scheduled to be presented for consideration by the House of Delegates at the 1972 Annual Meeting of the Ohio State Medical Association, May 8-11, in Cincinnati. These resolutions were received in the Columbus Office on or before March 9, thereby meeting the 60-day deadline. No resolution which failed to meet the 60-day deadline may be introduced unless the sponsor obtains at least two-thirds consent vote of the delegates present at the meeting.

Copies of all resolutions presented to the Columbus Office are being sent to individual Delegates and Alternate Delegates so that they may discuss them with their county medical societies.

A resolution to be considered by the House of Delegates must be typed in triplicate; introduced by a delegate or his duly accredited alternate seated in his place.

RESOLUTION NO. 1-72
Peer Review, PRSO
(By the Delaware County Medical Society)

RESOLUTION NO. 2-72
Peer Review, PRSO
(By the Ross County Medical Society)

RESOLUTION NO. 3-72
Notice to County Medical Societies in Re of Legislative Action
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 4-72
Local Review by Local Physicians
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 5-72
Report on Implementation on Resolutions Passed by the House of Delegates of the Ohio State Medical Association
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 6-72
Recognition for the Association of County Medical Executives, Inc. (ACME)
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 7-72
Change in OSMA Bylaws
(By the Council of the Ohio State Medical Association)

WHEREAS, Chapter 1, Section 6, of the present Bylaws of the Ohio State Medical Association presently provides as follows:

> "Section 6. **Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States Citizenship within a period of five years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such five year period or on January 1, 1974 whichever date is later."

WHEREAS, It has come to the attention of The Council that said section imposes a hardship upon noncitizen members of the Association who are undertaking to acquire United States citizenship, because the minimum time to acquire citizenship is often closer to six years than five years from date of filing a declaration of intention, and

WHEREAS, Ohio State Medical Association policy has been strongly to encourage membership in this Association of noncitizen physicians who seek and acquire United States citizenship within the time required by law; THEREFORE, BE IT

RESOLVED, That The Council recommend to the House of Delegates that Chapter 1, Section 6, of the Bylaws be amended as follows:

> "Section 6. **Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of six years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such six year period or on January 1, 1974 whichever date is later."

RESOLUTION NO. 8-72
Liaison with Medical Board
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 9-72
Proposed Solution to Current Malpractice Problems
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 10-72
Attorneys' Contingency Fees in Relation to Current Malpractice Problems
(By the Academy of Medicine of Cincinnati)

RESOLUTION NO. 11-72
Medical Advances Institute
(By the Delaware County Medical Society)

RESOLUTION NO. 12-72
Funding of Comprehensive Health Plans
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 13-72
Medicare Part B
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 14-72
Policy Statement on Alcoholism
(By the Academy of Medicine of Cleveland)

(Continued on Next Page)

RESOLUTION NO. 15-72
Grass Roots Involvement in AMA
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 16-72
Peer Review by Component Societies
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 17-72
Closed Panel or Prepaid Group Practice
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 18-72
Commending The Council of the OSMA
(By the Academy of Medicine of Cleveland)

RESOLUTION NO. 19-72
Honorary Membership Nomination
(By the Council of the Ohio State Medical Association)

RESOLUTION NO. 20-72
Medical Advances Institute
(By the Mahoning County Medical Society)

RESOLUTION NO. 21-72
Review of O.M.I., Inc., Coverages
(By the Defiance County Medical Society)

RESOLUTION NO. 22-72
Annual Chest X-ray Exams
(By the Defiance County Medical Society)

RESOLUTION NO. 23-72
Invoice for Health Care Under Medical Assistance Program
(By the Trumbull County Medical Society)

RESOLUTION NO. 24-72
Exposure of Failure of Government Medical Programs
(By the Richland County Medical Society)

RESOLUTION NO. 25-72
Proposed Amendment to the Bylaws of the Ohio State Medical Association
(By Delegates Joseph Bonta, M.D., Columbus and Thomas Morgan, M.D., Gallipolis)

WHEREAS, The present Bylaws of the Ohio State Medical Association now require that every resolution to be presented to the House of Delegates shall be filed with the Executive Director of the Association at least sixty (60) days prior to the Annual Meeting of the House of Delegates; and

WHEREAS, There have been increasing numbers of "Emergency Resolutions" presented at the opening session of the House of Delegates; and

WHEREAS, these "Emergency Resolutions" can be considered by the House of Delegates only if the reasons for the late submission are favorably considered by two-thirds (2/3) of the delegates present at the opening session; and

WHEREAS, the substance of any "Emergency Resolution" is not to be considered by the House of Delegates until the filing and transmittal requirements have been waived or dispensed with; and

WHEREAS, there has been a great tendency for the discussion by the members of the House of Delegates to concern itself with the substance of the resolution itself rather than with the reasons why it should or should not be declared an "Emergency Resolution," and

WHEREAS, An inordinate amount of time has been consumed in recent years at the meeting of the House of Delegates in deciding whether reasons for the late submission of these resolutions are acceptable to the House; and

WHEREAS, A more orderly procedure would be accomplished if "Emergency Resolutions" presented at the opening session of the House of Delegates were submitted to a Special Committee on Recent Resolutions of the House of Delegates for the purpose of deciding whether or not the filing and transmittal requirements are to be waived or dispensed with;

It is, therefore, proposed that the second sentence of Chapter 4, Section 8 of the Bylaws of the Ohio State Medical Association be amended to read as follows:

"No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived or dispensed with by the Special Committee on Recent Resolutions named to decide whether late submission was justified. This Special Committee shall be composed of the Immediate Past-President of the OSMA, the President-Elect of the OSMA, a member of Council chosen by the Council, and a member of the House of Delegates selected by the President. If a majority of the voting members of the Special Committee on Recent Resolutions vote favorably for waiving or dispensing with the filing and transmittal requirement, then such resolution shall be recommended for presentation to the House of Delegates at its opening session in the regular manner. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the Committee no less than 12 hours prior to the opening session of the House of Delegates."

RESOLUTION NO. 26-72
Medical Advances Institute
(By Richard E. Hartle, M.D., Delegate, Fairfield County Medical Society)

RESOLUTION NO. 27-72
Ohio Welfare Department Forms
(By the Delegates, Second Councilor District)

RESOLUTION NO. 28-72
Reaffirm Autonomy in all Peer Review Activities
(By the Columbiana County Medical Society)

RESOLUTION NO. 29-72
Medicare and Medicaid
(By the Huron County Medical Society)

RESOLUTION NO. 30-72
Assessment for Preservation of Constitutional Rights
(By the Huron County Medical Society)

RESOLUTION NO. 31-72
Involuntary Servitude
(By the Huron County Medical Society)

RESOLUTION NO. 32-72
H.R. 7182
(By the Huron County Medical Society)

RESOLUTION NO. 33-72
Medical Advances Institute
(By the Huron County Medical Society)

RESOLUTION NO. 34-72
Health Care—Negotiable Services
(By the Huron County Medical Society)

RESOLUTION NO. 35-72
Liberty to Contract
(By the Huron County Medical Society)

RESOLUTION NO. 36-72
Average Length of Stay
(By the Huron County Medical Society)

RESOLUTION NO. 37-72
Nationwide Educational Campaign
(By the Huron County Medical Society)

RESOLUTION NO. 38-72
AMA Reorganization
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 39-72
Unit Rule
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 40-72
Phase II
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 41-72
H.R. 7182
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 42-72
H.M.O.'s
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 43-72
Medical Advances Institute
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 44-72
Regional Medical Programs
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 45-72
Capitation (and Ethics)
(By the Council of the Lake County Medical Society)

RESOLUTION NO. 46-72
Dissolution of the American Board of Nuclear Medicine
(By James Tye, M.D., Dayton [on behalf of the Radiologists] and R. G. Thomas, M.D., Elyria [at the request of the Ohio Society of Pathologists])

RESOLUTION NO. 47-72
Homicide by Handguns
(By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 48-72
Development and Comparison of Improved Health Care Systems
(By the Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 49-72
H.R. 1
(By C. G. Madsen, Jr., M.D., Delegate, Lake County Medical Society)

RESOLUTION NO. 50-72
Waiver of OSMA Dues at Age 80
(By Felix A. Pesa, M.D., Delegate, Mahoning County Medical Society)

WHEREAS, The American Medical Association, and other medical organizations, do not require, their members to pay dues after the age of 70, and

WHEREAS, A physician reaching the age of 80 has, in the normal course of his career, paid dues to a variety of medical organizations for a long time, and

WHEREAS, Most physicians having reached the age of 80 have limited their practice in varying degrees, and

WHEREAS, The active physicians of Ohio owe much to their colleagues who have preceded them and want to show their appreciation, and

WHEREAS, The Ohio State Medical Association has, in the past, based payment of dues on retirement, rather than age, THEREFORE, BE IT

RESOLVED, That, beginning with the collection of dues for 1973, the Ohio State Medical Association issue a waiver of dues to all members who have passed their 80th birthday in the year previous to that for which dues are being collected.

RESOLUTION NO. 51-72
Non-Therapeutic Use of Drugs by Athletes
(By the Delegation, Academy of Medicine of Columbus and Franklin County)

RESOLUTION NO. 52-72
Phenylketonuria
(By the Madison County Medical Society)

RESOLUTION NO. 53-72
Scotochromogen
(By the Madison County Medical Society)

RESOLUTION NO. 54-72
VDRL
(By the Madison County Medical Society)

RESOLUTION NO. 55-72
Hospital Board
(By the Madison County Medical Society)

RESOLUTION NO. 56-72
Relative Value Fee Schedule
(By the Allen County Academy of Medicine)

RESOLUTION NO. 57-72
Per Diem for Delegates
(By the Summit County Medical Society)

RESOLUTION NO. 58-72
1973 Annual Meeting
(By the Summit County Medical Society)

RESOLUTION NO. 59-72
Health Maintenance Organizations
(By the Summit County Medical Society)

RESOLUTION NO. 60-72
Critical Need to Reevaluate Available Resources to Support Hospital-Based Training Research and Educational Programs
(By Frederick P. Osgood, M.D., Delegate, Academy of Medicine of Toledo and Lucas County)

RESOLUTION NO. 61-72
Revocation of O.M.I. Utilization Review Program
(By the Stark County Medical Society)

RESOLUTION NO. 62-72
O.M.I., Inc. "Hold Harmless" Position
(By the Stark County Medical Society)

RESOLUTION NO. 63-72
O.M.I. "Hold Harmless"
(By the Huron County Medical Society)

RESOLUTION NO. 64-72
Withdrawal of O.M.I. from National Association of Blue Shield Plans
(By the Stark County Medical Society)

Ohio Radiological Society Schedules Cincinnati Meeting, May 12-14

The Ohio Radiological Society has scheduled a Scientific Program in Cincinnati, Friday, Saturday, and Sunday, May 12, 13, and 14 (immediately after the Annual Meeting of the Ohio State Medical Association).

First event is a Buffet luncheon at the Crest Hills Country Club, followed by golf and other outdoor activities. Cocktails and dinner are scheduled on the Johnston Party Boat with a cruise on the Ohio.

On Saturday, May 13, registration opens at 8:30 a.m. at Stouffer's Inn, downtown Cincinnati.

Guest lecturer is C. John Hodson, CRCP, FRCP, FFR, professor and chairman, Department of Radiology, Memorial University of Newfoundland, Canada.

Saturday Program

Destructive Lesions of the Renal Parenchyma—
Dr. Anthony F. Lalli

What Happens, and Can Happen, in Ureteric Obstruction—
Dr. Hodson

Diagnostic and Prognostic Connotations of Radiographic Studies in Hypertension—
Dr. Thomas F. Meaney

Drugs, Bugs and the Kidney—
Dr. Hodson

The Arteriographer Looks at the Kidney—
Dr. Charles H. Kuntz

The Role of Radioisotopes in the Evaluation of Renal Disease—
Dr. Donald Gunderson

Sunday Program

Brunch and business meeting beginning at 8:30 a.m.

The Radiologist Looks at Renal Anatomy—
Dr. Hodson

Therapy Workshop—Wilms' Tumor—

Diagnostic Radiological Evaluation
Dr. William McSweeney

Surgery—
Dr. J. Cox

Chemotherapy—
Dr. A. Mauer

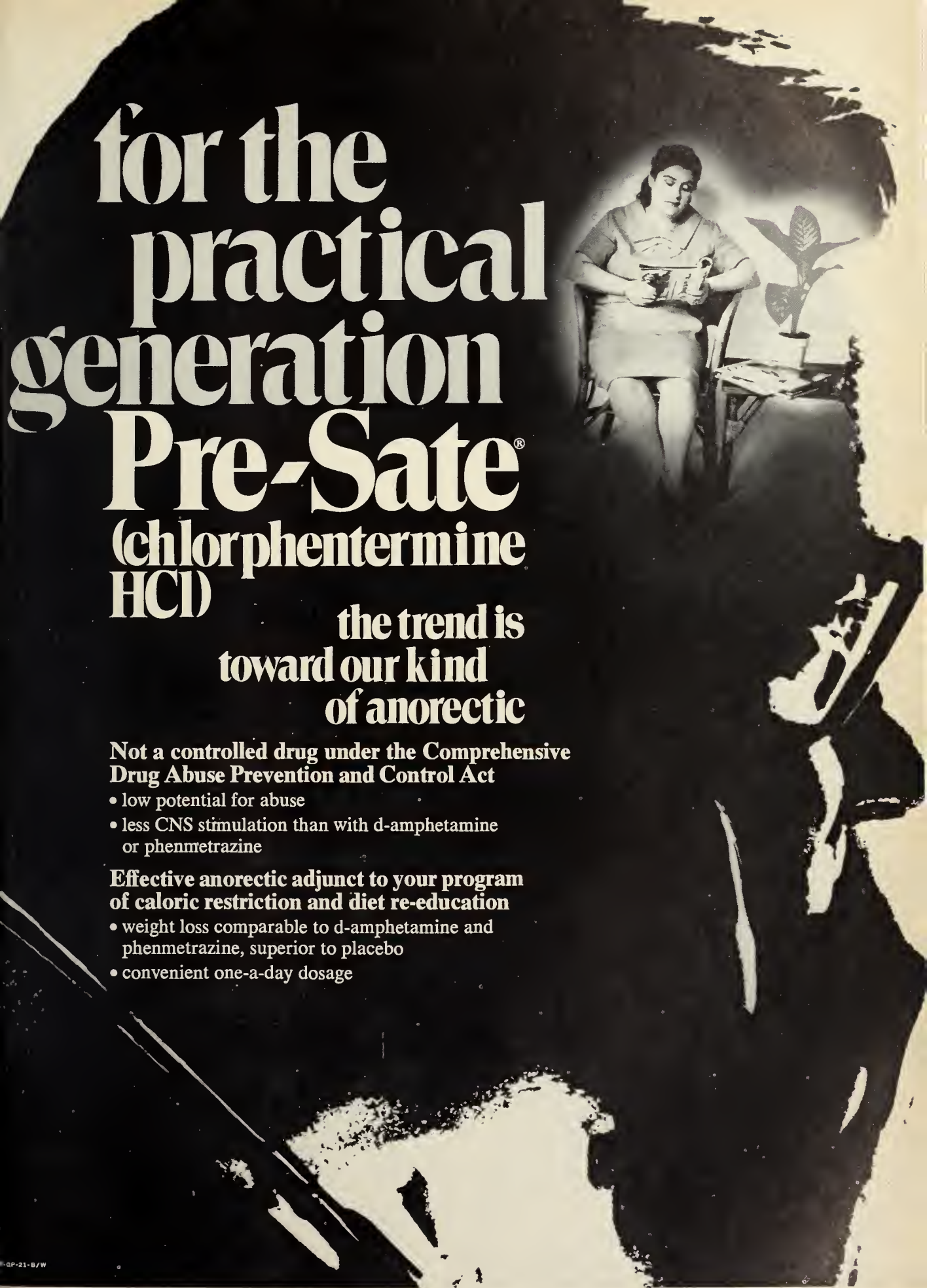
Radiation Therapy—
Dr. B. Aron

Diagnostic Film Reading Session—
Dr. Benjamin Felson, Moderator

For additional information, contact, Dr. Harry Horwitz or Dr. Harold Schneider, cochairmen, Department of Radiology, Cincinnati General Hospital, Burnet Avenue, Cincinnati 45229.

Pre-Sate®
(chlorphentermine HCl)
CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
Full information available on request.

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Not a controlled drug under the Comprehensive Drug Abuse Prevention and Control Act

- low potential for abuse
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Effective anorectic adjunct to your program of caloric restriction and diet re-education

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- convenient one-a-day dosage

-QP-21-B/W

Pre-Sate® (chlorphentermine HCl)...the increasingly practical appetite suppressant



When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25—30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

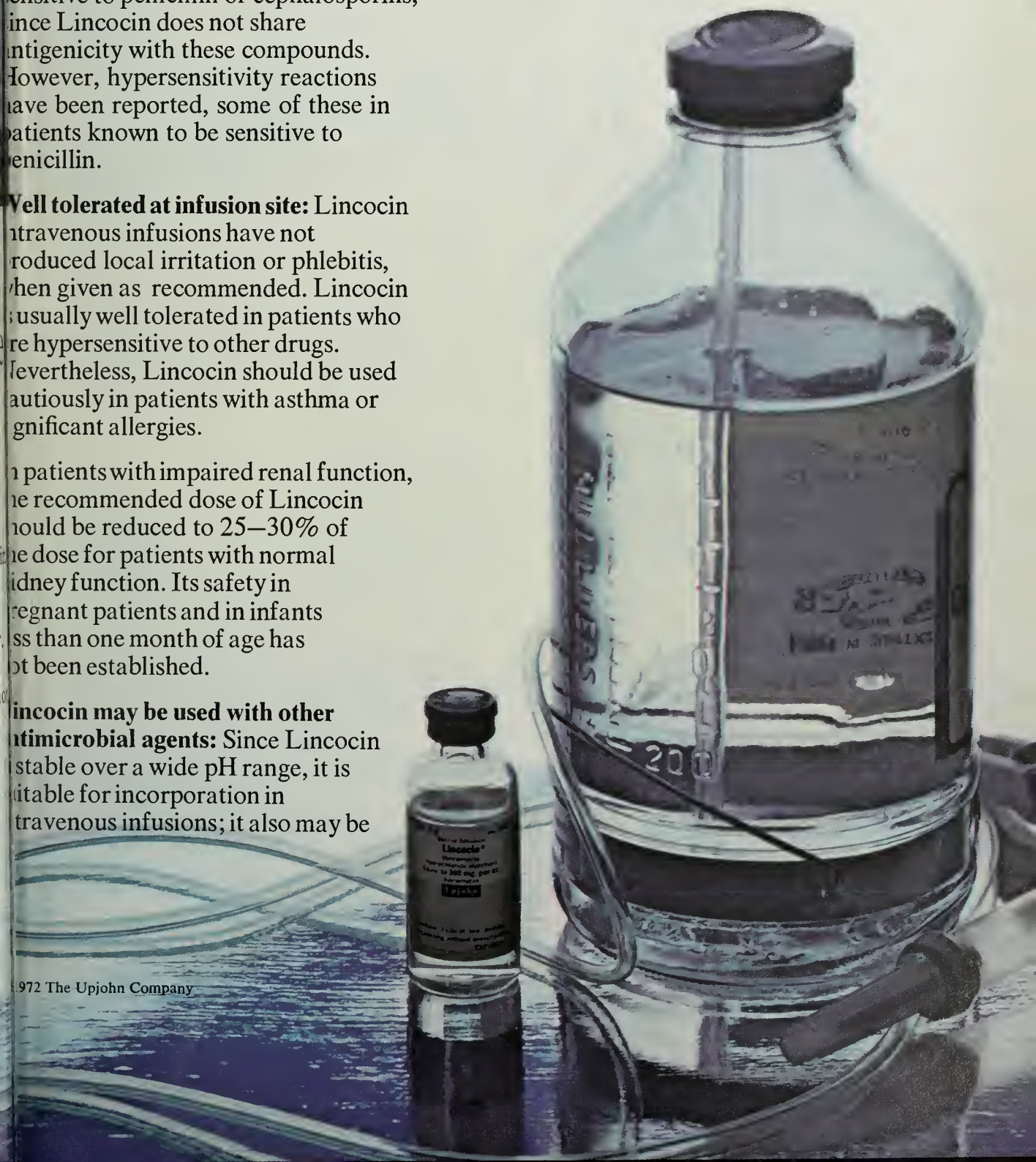
Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 mg* Capsules—bottles of 24 and 100. *Sterile Solution, 300 mg per ml*—2 and 10 ml vials and 2 ml syringe. *Syrup, 250 mg per 5 ml*—60 ml and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

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Don't Miss

CHEST DAY at the O.S.M.A.

Sponsored jointly by the Ohio Chapter, American College of Chest Physicians, and the Ohio Society of Thoracic Surgeons.

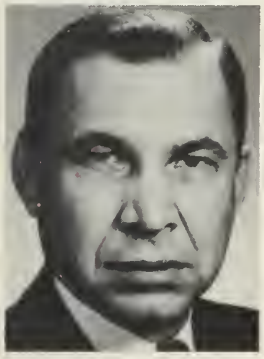
Wednesday, May 10th, 1972 Rooms 202 and 206 Cincinnati Exposition Center

MORNING SESSION: CARDIAC DISEASE

Moderator: R. Donald Woodson, M.D., F.A.C.C.P., President, Toledo, Ohio Chapter, American College of Chest Physicians.

8:30 **Complimentary Coffee and Rolls**

9:00 **Early Differentiation of Cyanotic Congenital Heart Disease**



Don M. Hosier, M.D., Director, Division of Cardiology, Columbus Children's Hospital; and Professor of Pediatrics, OSU College of Medicine.



Primary Discussant — Samuel Kaplan, M.D., Director, Division of Cardiology, Children's Hospital; and Professor of Pediatrics and Associate Professor of Internal Medicine, UC College of Medicine.

9:20 **Surgical Management of Cyanotic Congenital Heart Disease**



John S. Vasko, M.D., Associate Professor of Surgery, (Division of Thoracic Surgery), OSU College of Medicine.



Primary Discussant—James A. Helmsworth, M.D., Director, Division of Cardiovascular and Thoracic Surgery, Cincinnati General Hospital; and Professor of Surgery, UC College of Medicine.

9:40 **Recent Advances in Cardiac Valve Surgery**



Richard A. DeWall, M.D., Chief, Experimental Surgery Laboratory, Cox Heart Institute; Chief, Cardiovascular Surgery, Kettering Hospital, Dayton.



Primary Discussant — William H. Falor, M.D., Chief, Division of Thoracic Surgery, Akron City Hospital and Children's Hospital of Akron.

10:00 **Clinical Applications of Cardiac Pacing**



Anthony R. Geraci, M.D., Associate Director, Cardiovascular Laboratory, Toledo Hospital, and Associate Clinical Professor of Medicine, Medical College of Ohio.



Primary Discussant — J. William Spickler, Ph.D., Head, Physiology and Engineering Section, Cox Heart Institute, Dayton, Ohio.

(Continued on Next Page)

10:20 Coffee Break

10:40 **Pathophysiology for the Clinician: Congestive Heart Failure**



ROBERT C. LITTLE, M.D., Professor and Chairman, Department of Physiology and Assistant Professor of Medicine, the OSU College of Medicine.

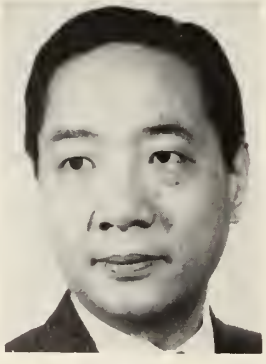


Primary Discussant — DON C. NOUSE, M.D., Chairman, Department of Medicine and Cardiology, Toledo Hospital; and Clinical Associate, Internal Medicine, Medical College of Ohio.

11:00 **Can Electrocardiography really Detect Coronary Artery Disease?**



HERMAN K. HELLERSTEIN, M.D., Associate Physician, University Hospitals of Cleveland; and Associate Professor of Medicine, Case Western Reserve University School of Medicine.

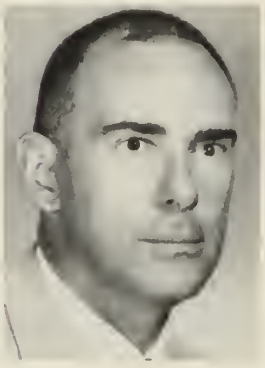


Primary Discussant — TE-CHUAN CHOU, M.D., Associate Professor of Medicine, UC College of Medicine.

11:20 **The Why and When of Coronary Angiography**



F. MASON SONES, JR., M.D., Head, Department of Cardiovascular Disease and the Cardiac Laboratory, Cleveland Clinic Foundation.



Primary Discussant — CHARLES F. WOOLEY, M.D., Associate Professor of Medicine, OSU College of Medicine.

11:40 **Coronary Atherosclerosis: The Surgical Attack on a Medical Disease**



LAURENCE K. GROVES, M.D., Staff Member, Department of Thoracic and Cardiovascular Surgery, Cleveland Clinic Foundation.



Primary Discussant — JOHN J. TURNER, M.D., Vice-Chief of Surgery and Chief of Thoracic and Cardiovascular Surgery, Northside Hospital, Youngstown.

12:10 **Business Luncheon**

(Membership and invited guests of Ohio Chapter, American College of Chest Physicians): Bronze Room B, Stouffer's Cincinnati Inn. Guest Speaker: *Albert Soffer,* M.D., F.A.C.C.P., Executive Secretary, American College of Chest Physicians: **"The Woes and Joys of a Medical Editor."**

AFTERNOON SESSION: PULMONARY AND ESOPHAGEAL DISEASE

Moderator: H. Gene Ewy, M.D., F.A.C.S., President, Columbus, Ohio Society of Thoracic Surgeons.

1:30 Emergency Management of Thoracic Trauma

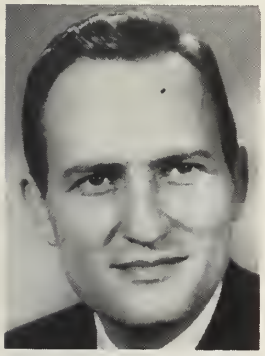


CHARLES V. MECKSTROTH, M.D., Associate Professor of Surgery (Division of Thoracic Surgery), OSU College of Medicine.



Primary Discussant — JOHN B. FLEGE, JR., M.D., Director, Department of Cardiovascular Surgery. The Christ Hospital; and Assistant Clinical Professor of Cardiovascular and Thoracic Surgery, UC College of Medicine.

1:50 Cavitary Lesions of the Lung: Which Is Which?



JEROME F. WIOT, M.D., Director, Department of Radiology, Cincinnati General Hospital; and Professor of Radiology, UC College of Medicine.



Primary Discussant—LEONARD M. HEINZ, M.D., Associate Radiologist, Toledo Hospital.

2:10 Newer Diagnostic Techniques in Obscure Lung Disease



PETER B. BARLOW, M.D., Assistant Chief, Pulmonary Section B, Cleveland Veterans Administration Hospital; and Instructor of Medicine, Case Western Reserve University School of Medicine.



Primary Discussant — ARNO F. FREIHOFER, M.D., Division of Pulmonary Disease, Cincinnati General Hospital; and Assistant Professor of Medicine, UC College of Medicine.

2:30 Is Lung Cancer Actually Curable?



KARL P. KLASSEN, M.D., Director, Division of Thoracic Surgery, Children's Hospital and University Hospital; and Professor of Surgery (Division of Thoracic Surgery) OSU College of Medicine.



Primary Discussant — MORRIS W. SELMAN, M.D., Division of Thoracic and Cardiovascular Surgery, Toledo and St. Vincent's Hospitals, and Clinical Associate in Thoracic Surgery, Medical College of Ohio.

2:50 Coffee Break

(Continued on Next Page)

3:10 **A Rational Approach to Esophageal Malignancy**



JAY L. ANKENEY, M.D., Director of Cardiothoracic Surgery, University Hospitals of Cleveland; and Professor of Surgery, Case Western Reserve University School of Medicine.



Primary Discussant — PATRICK J. MOORE, M.D., Ohio Heart and Thoracic Surgery Center; Chief, Division of Thoracic Surgery, St. Anthony Hospital, Columbus.

3:30 **Pulmonary Tuberculosis in 1972: Have We Won?**



ROBERT G. LOUDON, M.B., Director of Pulmonary Disease Division, UC Medical Center; and Professor of Medicine, UC College of Medicine.



Primary Discussant—JOSEPH F. TOMASHEFSKI, M.D., Director, Pulmonary Function Laboratory and Staff, Department of Pulmonary Disease, Cleveland Clinic Foundation.

3:50 **Hypersensitivity Lung Disease: An Uncommonly Diagnosed Common Entity**



BARNEY M. WISINGER, M.D., Chief, Division of Pulmonary Medicine and Director of Pulmonary Function Laboratory and Inhalation Therapy, University Hospital; and Assistant Clinical Professor of Medicine, Medical College of Ohio.



Primary Discussant — WILLIAM F. HUGHES, M.D., Assistant Clinical Professor of Medicine, OSU College of Medicine.

4:10 **Acute Respiratory Distress of the Newborn**



RONALD J. LUBBE, M.D., Director, Newborn Nursery, Jewish Hospital; and Assistant Professor of Pediatrics, UC College of Medicine.



Primary Discussant — HERMAN W. REAS, M.D., Deputy Coordinator, Northwestern Ohio Regional Medical Program; and Assistant Clinical Professor of Pediatrics, Medical College of Ohio.

5:00 **Business Meeting and Cocktails**
(Membership and invited guests of Ohio Society of Thoracic Surgeons).

★ ★ ★ *Join us for complimentary continental breakfast and spend the day!* ★ ★ ★

1972 Curbstone Consultation Seminars

Curbstone Consultations are being held two mornings during the 1972 OSMA Annual Meeting at the Cincinnati Exposition Center.

Register now for one of the Seminars, in the order of preference. Each Seminar will be limited to the first 30 persons registered in order to maintain a small, informal exchange of ideas and questions among those in attendance. If you are unable to attend, please notify the OSMA office so that your place may be assigned to someone else.

DISCUSSANT LEADERS AND SUBJECTS

Wednesday, May 10, 1972

Mr. William J. Lee, Columbus
Administrator, State Medical Board of Ohio
- "Know Your State Medical Board and Its Activities"

Anthony J. Ruppersberg, M.D., Columbus
Chairman, OSMA Committee on Maternal Health
- "OB Emergencies"

Donald J. Vincent, M.D., Columbus
Chairman, OSMA Committee on Medicine and Religion
- "What's Going On In Medicine and Religion?"

Thursday, May 11, 1972

Mr. Alan R. Vogeler, L.L.B., Cincinnati
Law Offices of Kyte, Conlan, Wulsin & Vogeler
- "Have You Cured Your Own Estate Problems?"
  (A Seminar on estate planning, including retirement and welfare plans, and Ohio and Federal income estate taxes)

Paul A. Jones, M.D., Zanesville
Chairman, OSMA Title XIX, Subcommittee of the Committee on Government Medical Care Programs
- "The Welfare Problem: Is There A Solution?"

Marvin McClellan, M.D., Cincinnati
Member, Academy of Medicine of Cincinnati Committee on School Health
- "Immunization Idiocy"

Wednesday, May 10, 1972
9:00 - 10:30 A.M.

(Indicate Order of Choice 1, 2, or 3)

- ☐ "Know Your State Medical Board and Its Activities"
- ☐ "OB Emergencies"
- ☐ "What's Going On In Medicine and Religion?"

Thursday, May 11, 1972
9:00 - 10:30 A.M.

(Indicate Order of Choice 1, 2, or 3)

- ☐ "Have You Cured Your Own Estate Problems?"
- ☐ "The Welfare Problem: Is There A Solution?"
- ☐ "Immunization Idiocy"

NAME (Please Print) _____

Address _____

(Mail this card to OSMA, 17 South High Street, Suite 500, Columbus, Ohio 43215)

A LOOK INTO THE FUTURE

1972 OSMA ANNUAL MEETING

MAY 8-11, 1972 CINCINNATI, OHIO

Stouffer's Cincinnati Inn — Headquarters Hotel
Cincinnati Exposition Center — Meeting Rooms and Exhibit



An array of subjects will be covered during the 1972 Annual Meeting. Regar less of your specialty or specific interest, OSMA has gone all out to provi something which will be useful to you in the ensuing year. Make arrangemen now to spend the week of May 7 in Cincinnati, Ohio. Visit the Scientifi Health-Education and Technical Exhibits in the beautiful Cincinnati Expositi Center. All scientific meetings and House of Delegates meetings will be held the Exposition Center. All hotel facilities are within minutes from the Expo tion Center.

The Ohio State Medical Association and the Medi-Art Club of the Acaden of Medicine of Cincinnati will be sponsoring a PHYSICIAN'S ART SHO All Members of the Ohio State Medical Association and their wives and Me bers of the Medi-Art Club are invited to compete in this show. All interest parties please get in touch with Harry H. Fox, M.D., Chairman, Art Sh Committee, 19 West 8th, 368 Doctors Building, Cincinnati, Ohio 45202 f particulars.

OMPAC LUNCHEON

Wednesday, May 10, 1972

11:30 A.M.

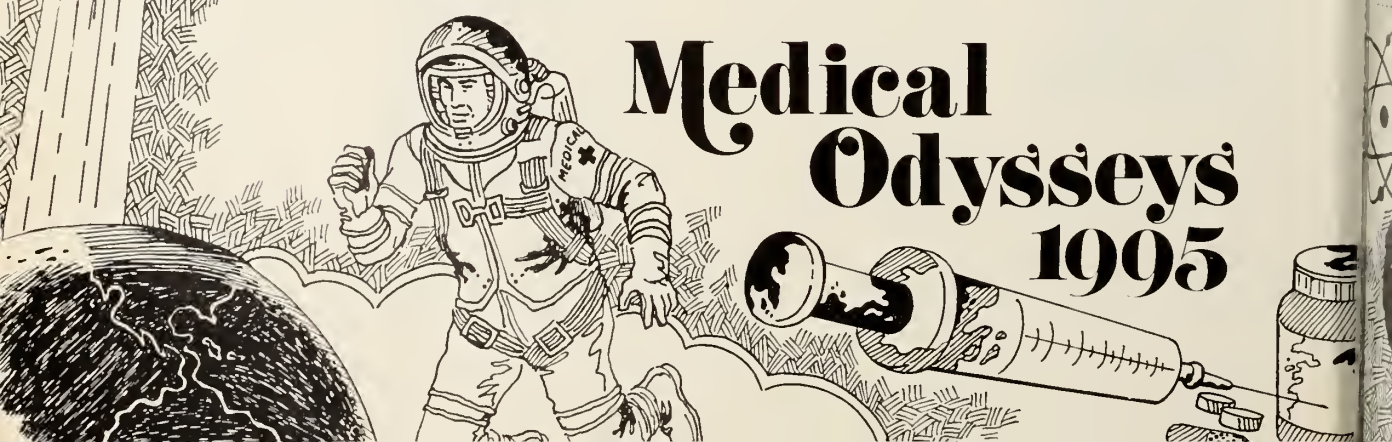
Speaker: Mr. Robert D. Novak
Washington Columnist and Author

Subject: "Politics — 1972"

"Riverboat Odysseys: 1895"

Wednesday evening, May 10, 197
7:00 P.M.

Johnston Party Boats
Foot of Broadway



Medical Odysseys 1995

SETS THE PACE FOR THE...

PRE-REGISTRATION

All persons pre-registered may pick up their badge, program and tickets for OMPAC luncheon and "Riverboat Odysseys: 1895" party at the pre-registration desk in your name. Clip the coupon, fill out the information requested along with your **check in the proper amount** so that we may reserve tickets for you. This one step now will save you time later.

Annual Meeting Pre-Registration and Ticket Form

SOCIAL FUNCTION TICKET RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to: Ohio State Medical Association

Mail this form to: Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215

Wednesday, May 10, 11:30 A.M.

"OMPAC Luncheon"

Cincinnati Exposition Center

$5.00 per person

Number_____

Wednesday, May 10, 7:00 P.M.

"Riverboat Odysseys: 1895"

Johnston Party Boats
Foot of Broadway

$12.00 per person
(Special Price to Exhibitors of $9.00 per person)

Number_____

Name_____
(Please Print)

Address_____
(Number and Street) (City) (State)

I am:

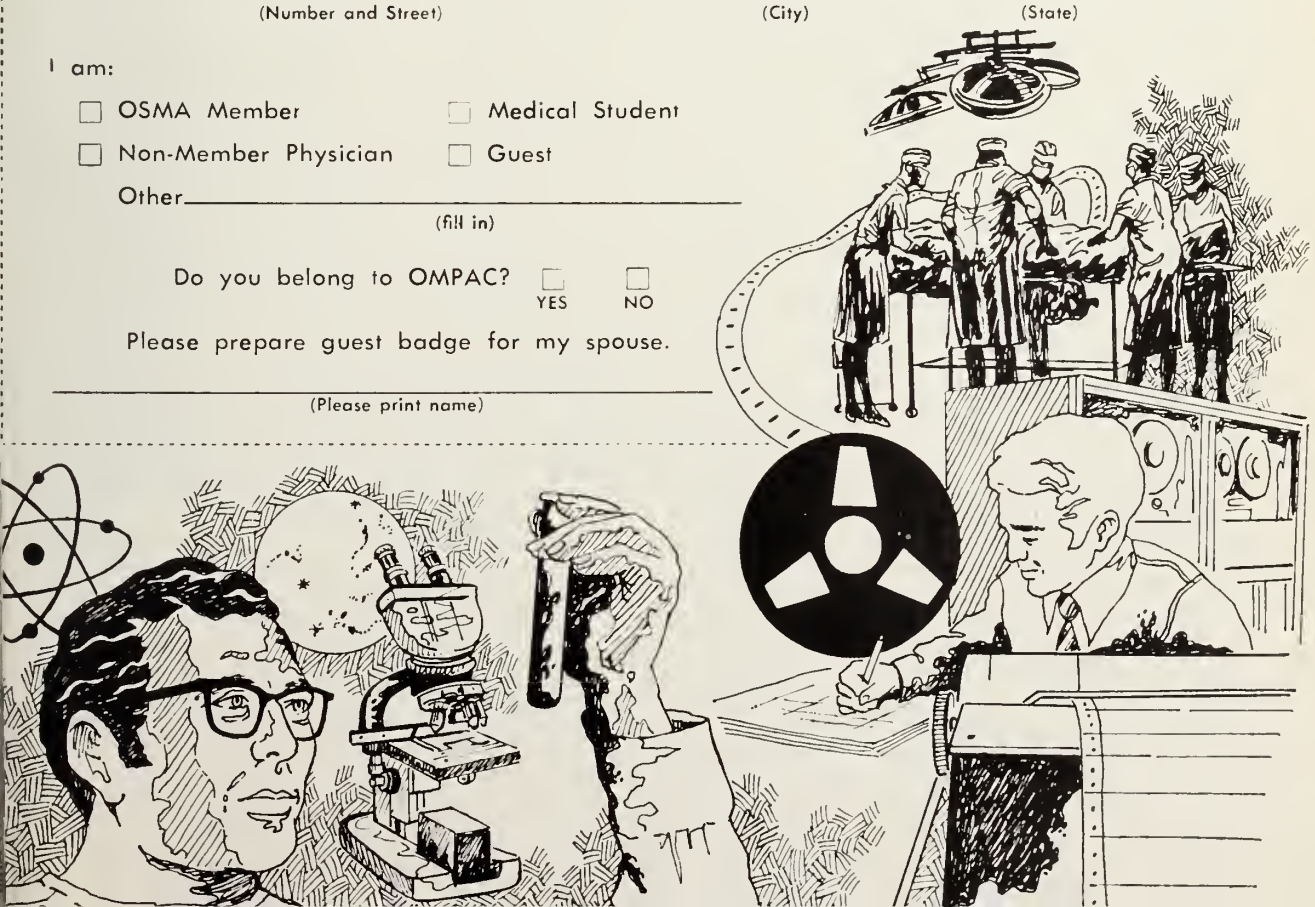
- ☐ OSMA Member
- ☐ Medical Student
- ☐ Non-Member Physician
- ☐ Guest

Other_____
(fill in)

Do you belong to OMPAC? ☐ YES ☐ NO

Please prepare guest badge for my spouse.

_____
(Please print name)



Two-Day Clinicopathologic Symposium

Wednesday and Thursday, May 10 and 11
Cincinnati Exposition Center

"CALCIUM — METABOLISM, MEASUREMENT AND MALADIES"

This Symposium is sponsored by the College of American Pathologists (CAP) and the Ohio Society of Pathologists in cooperation with the Section on Pathology of the Ohio State Medical Association. Also a Regional Meeting of the CAP and an Event in the Year of Pathology, 1972.

PROGRAM

Wednesday, May 10
Morning Session

Calcium Metabolism

Presiding: William A. Hawk, M.D., Cleveland, President, Ohio Society of Pathologists, Cleveland Clinic.

9:00 a.m. **Introduction to Symposium**—Robert C. Horn, M.D., Vice President, College of American Pathologists, Henry Ford Hospital, Detroit, Michigan.

9:15 a.m. **Calcium Homeostasis—An Overview** —Thomas G. Skillman, M.D., Professor of Medicine and Director of Endocrinology and Metabolism, Ohio State University College of Medicine, Columbus.

9:45 a.m. **Parathormone — Its Physiological Role and Clinical Significance** — Richard E. Goldsmith, M.D., Professor of Medicine, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati.

10:15 a.m. Break to View Exhibits

10:45 a.m. **Thyrocalcitonin — Its Physiological Role and Clinical Significance** — Paul L. Munson, Ph.D., Professor of Pharmacology and Endocrinology, Chairman, Department of Pharmacology, University of North Carolina at Chapel Hill, North Carolina.

11:15 a.m. Panel Discussion — Questions and Answers

Moderator: J. Beach Hazard, M.D., Formerly Chairman of the Division of Laboratory Medicine, Cleveland Clinic, Cleveland.

Panelists:
Richard E. Goldsmith, M.D.
Paul L. Munson, Ph.D.
Thomas Skillman, M.D.

Wednesday, May 10
Afternoon Session

Calcium Measurement

Presiding: Lawrence J. McCormack, M.D., Speaker of the House of Delegates, College of American Pathologists, Cleveland Clinic, Cleveland.

1:30 p.m. **The Reliability of Calcium Measurement in the U.S.A. Today** — Roger K. Gilbert, M.D., Member, Survey Committee, College of American Pathologists, Director of Laboratories, Waterbury Hospital, Waterbury, Connecticut.

2:30 p.m. Break to View Exhibits

3:00 p.m. **Assurance of Quality — The Practical Role of the CAP** — Pierre W. Keitges, M.D., Member of Standards Committee of the CAP, Menorah Medical Center, Kansas City, Missouri.

4:00 p.m. Discussion

Thursday, May 11
Morning Session

Calcium Maladies: Nine CPC's in Miniature

Panel Discussion

Moderator: J. Beach Hazard, M.D.

Panelists:
Robert Allman, M.D. (Associate Director of Section of Radiology, Armed Forces Institute of Pathology, Bethesda, Maryland)
Richard E. Goldsmith, M.D.
Paul L. Munson, Ph.D.
Thomas G. Skillman, M.D.

9:00 a.m. Cases 1, 2 and 3

10:15 a.m. Break to View Exhibits

10:45 a.m. Cases 4 and 5

11:30 a.m. Business Meeting, Ohio Society of Pathologists

Thursday, May 11
Afternoon Session

2:00 p.m. Cases 6 and 7

3:00 p.m. Break to View Exhibits

3:30 p.m. Cases 8 and 9

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.



Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899



a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® can be compared to codeine in analgesic efficacy, it is not a narcotic. So patients receiving Talwin for prolonged periods face fewer of the consequences you've come to expect with narcotic analgesics. And that, in the long run, can mean a better outlook for your chronic-pain patient.

Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (1583)

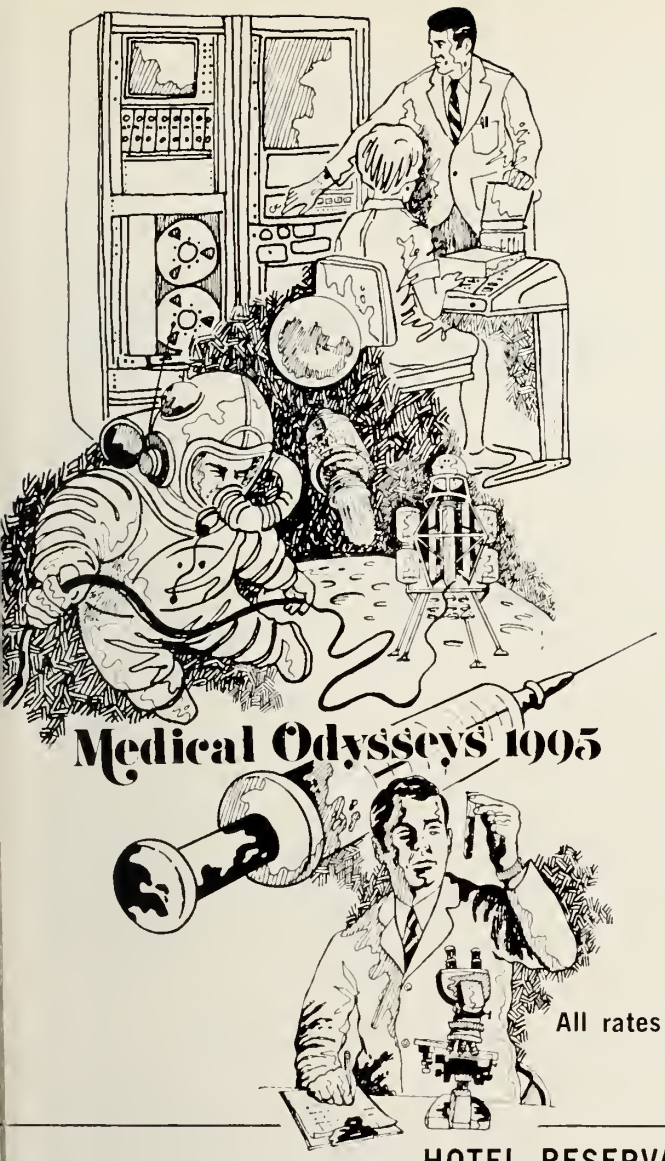
50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic



Make Your Hotel Reservations For The 1972 OSMA Annual Meeting

MAY 8-11
CINCINNATI, OHIO

STOUFFER'S CINCINNATI INN
150 West Fifth Street
Cincinnati, Ohio 45202
(OSMA Headquarters)

Singles	$17.50 - $23.50
Doubles	$22.50 - $27.50
Twins	$24.50 - $36.50

SHERATON-GIBSON HOTEL
421 Walnut St.
Cincinnati, Ohio 45201

Singles	$12.50 - $21.00
Doubles or Twins	$18.00 - $27.00

All rates subject to change. If you plan to share a room, please indicate name of roommate.

Mail Today

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Cincinnati, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 8-11 (or for period indicated).

_____ Single Room _____ Twin Room

_____ Double Room Other Accommodations _____

Price Range _____ Guaranteed _____

Arrival: May _____ at _____ A.M. _____ P.M.

Departure: May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Name _____

Address _____

_____

"Medicine's Socio-economic Forecast"

Physicians Project into the Future by Providing a Full-Day Program on Socio-economic Subjects Which Affect Medicine

This program is cosponsored by the Ohio State Medical Association, Ohio Society of Internal Medicine and the OSMA Section on Internal Medicine. This particular program could be entitled "Medical Odysseys: 1995" in keeping with the general theme of the 1972 Annual Meeting. There has been an increasing demand from the OSMA membership to have programming on not only scientific subjects but socio-economic subjects which affect the physician and his effectiveness in the practice of medicine. Persons chosen to speak on the various subjects and panels are knowledgeable and authoritative on their subjects. Another program designed with YOU in mind, Doctor!

PROGRAM
Wednesday, May 10, 1972
Morning Session

Presiding: W. Thomas Washam, M.D., Chillicothe, Assistant Professor, Department of Preventive Medicine, Ohio State University

"Medical Student Field Assignment: Community Health Rotation — OSU College of Medicine"

9:30-10:15 a.m. Speakers: Robert E. Reiheld, M.D., Orrville, Chairman, OSMA Committee on Rural Health and Martin D. Keller, M.D., Columbus, Professor, Department of Preventive Medicine, Ohio State University

10:15-10:45 a.m. Break for Tour of Exhibits

"OSMA Activities in Professional Standards Review Organization"

10:45-11:15 a.m. Speaker: James L. Henry, M. D., Grove City, Chairman, OSMA Committee on Peer Review; and President of Medical Advances Institute

11:15-11:30 a.m. Question and Answer Period

11:30-1:30 p.m. OMPAC Luncheon — Tickets on sale for $5.00 per person

Speaker: Mr. Robert D. Novak, Washington Columnist and Political Analyst

Subject: **"Politics 1972"**

Wednesday, May 10
Afternoon Session

Presiding: William A. Millhon, M.D., Columbus, President, Ohio Society of Internal Medicine

"Doctor, is an HMO or Medical Foundation a Part of Your Future?"

2:00-2:30 p.m. **HMO's**

Speaker: Vernon E. Wilson, M.D., Administrator, Health Services and Mental Health Administration, Rockville, Maryland; and member of the AMA's Council on Medical Education and of the Liaison Committee on Medical Education

2:30-3:00 p.m. **Medical Foundations**

Speaker: John F. Farrington, M.D., Boulder, Colorado; Board Certified, American Board Internal Medicine; Professional Appointment, University of Colorado School of Medicine and in private practice with the Associated Internists of Boulder

3:00-3:30 p.m. Break for Tour of Exhibits

3:30-4:30 p.m. **Panel Discussion on HMO's and Foundations**

Moderator: William A. Millhon, M.D., Cobus

Panel Participants: Drs. Wilson and Farrington; and Doctors Robert E. Howard, Cincinnati, Chairman, OSMA Committee on Ad Hoc Committee on Health Care Delivery Systems; H. William Porterfield, Columbus, Member, OSMA Committee on Ad Hoc Committee on Health Care Delivery Systems and Stephen P. Hogg, M.D., Cincinnati, Midwest Medical Foundation

Medi Club

IT'S MEDI CLUB FOR MEDICAL MEETINGS

A Congenial Meeting Place For The Professional In Medicine

GALA EVENT

For The Members Of The Ohio State Medical Association

MONDAY EVENING

MAY 8, 1972

5:00 p.m. 'til 1:00 a.m.

Music, Cocktails, Complimentary Late Evening Buffet

Members, Wives and Guest Cordially Invited

TUESDAY

MAY 9, 1972

Lunch — with complimentary bus transfer to and from Convention Center — Medi Club

Free ticket to Contemporary Arts Center

Buses will stop at the Art Center on the return trip from Medi-Club to the Convention Center

Members, Wives and Guest Cordially Invited

320 BROADWAY CINCINNATI, OHIO 45202

The Woman's Auxiliary and

Plan a FUN EVENING

– A – B

Tuesday Evening, May 9

The Medi-Art Club of the Academy of Medicine of Cincinnati and the Woman's Auxiliary to the Ohio State Medical Association have arranged a choice of activities for your free time on Tuesday, May 9. You can watch a ball game, absorb a bit of culture, or have a nightclub fling — all in new downtown Cincinnati. Take your pick and sign up for one of the events outlined on these pages.

A is for ART---

(Plan A)

Cash Bar at 6:00 p.m., followed by Dinner at 7:00 p.m.

To be held in the Academy Building, First Floor, 320 Broadway, Cincinnati.

Price: $7.00 per person (Use coupon below and make checks payable to the Medi-Art Club).

Speaker: Richard Boyle, Curator of Paintings, Cincinnati Art Museum
Subject: "Twentieth Century Paintings"

B is for BALL---

(Plan B)

Have strip steak dinner in the Medi-Club, 320 Broadway (lower level) and walk over to Riverfront Stadium to see the Cincinnati Reds vs Chicago Cubs.

Time: Dinner at 6:00 p.m.; Ball game at 8:05 p.m.

Your Hostess: Mrs. Dale R. Wiethe.

LIMITED to 60 persons; advance sale only for dinner-ball game package.

Price: $10.50 per person (includes tax and tip).

Reservation for Plan A

Price: $7.00 per person _____ Number of persons

(Make checks payable to the Medi-Art Club)

Mail Reservations to: Harry H. Fox, M.D.
Medi-Art Club, Inc.
320 Broadway
Cincinnati, Ohio 45202

Enclosed is $_____ No Cancellations will be Accepted.

Name_____

Address_____

Reservation deadline — May 1

Medi-Art Club of Cincinnati

in just three easy steps–

– C

C is for CLUBBING AROUND---

(Plan C)

Have prime rib dinner at the Lookout House in Northern Kentucky. See the floor show featuring Lou Rawls; have one drink on the house. Continue on to the Playboy Club for the late floor show and two drinks.

Time: A chartered bus will pick you up at the Terrace Hilton at 7:00 p.m. and will also transport you from one Club to the other. You can walk back to your hotel from the Playboy on 7th Street and so can set your own curfew!

Your Hostess: Mrs. Constandinus Condorodis.

LIMITED to 50 persons; advance sale only for Night-Club Tour.

Price: $23.00 per person (includes tax and tip).

Reservation for Plans B and C

Make checks payable to: (Auxiliary Convention Fund)

Mail to: Mrs. Edward J. Bender
3610 Clifton Avenue
Cincinnati, Ohio 45220

(Plan B) Dinner and Ball game @$10.50 per person _____ Number

(Plan C) Dinner and Night-Club Tour @$23.00 per person _____ Number

Enclosed is check for $_____

Name_____

Address_____

Please clip and mail to Mrs. Bender

Tickets may be picked up at the Auxiliary Registration Desk in the lobby (8th floor) of the Terrace Hilton on Tuesday between 12 Noon and 3:00 p.m. Deadline for advance registration is May 1. If the limit is reached before your reservation arrives, your check will be returned to you.

A to Z Approach on the Etiology, Prevention and Treatment of Coronary Artery Disease

Cincinnati Physicians to Present OSMA Scientific Program

Tuesday, May 9, Cincinnati Exposition Center

A scientific program designed to answer the many questions from office diagnosis to management of difficult problems in Coronary Artery Disease, taking into consideration the systemic system of the "wholeman." This program will be of interest to **ALL physicians** in their everyday practice, and we are certain you will want to make it a MUST for your Annual Meeting Schedule.

PROGRAM
Tuesday, May 9, 1972
Morning Session

Presiding: John Albers, M.D., Cincinnati

9:00- 9:35 a.m. **Etiology and Prevention of Coronary Artery Disease** — Charles Glueck, M.D., Cincinnati

9:40-10:15 a.m. **Family Practitioner Looks at Coronary Artery Disease —**
- **Office Diagnosis**
- **Office Therapy**
- **When to Hospitalize — In-Patient Therapy**
- **When to Refer and Whom to Refer**

Speaker: Milton Gwinner, M.D., Cincinnati

10:15-10:45 a.m. Break for Tour of Exhibits

10:45-11:20 a.m. **Cardiologist Looks at Coronary Artery Disease —**
- **Pre- and Post-Infarction States**
- **Continued Uncontrolled Angina**
- **Persistent Arrhythmias**
- **When to Refer and Whom to Refer**

Speaker: Charles W. Abbott-Smith, M.D., Cincinnati

11:25-12:00 p.m. **Panel Discussion on Medical Treatment of Coronary Artery Disease —**

Moderator: John Albers, M.D., Cincinnati

Participants: Doctors Charles Glueck, Milton Gwinner, Charles W. Abbott-Smith and Georges Daoud

Tuesday, May 9, 1972
Afternoon Session

2:00-2:35 p.m. **Radiographic Diagnosis in Coronary Artery Disease —**
- **Whom to Catheterize**
- **When to Catheterize**
- **Diagnosis in Acute Infarction Period**
- **Complications of Catheterization**

Speaker: Georges Daoud, M.D., Cincinnati

2:40-3:15 p.m. **Surgical Management of Coronary Artery Disease —**
- **Revascularization Procedures**
- **Aneurysms of Left Ventricle**
- **Pacemakers**
- **Counter Pulsation Procedures Using Intra-Aortic Balloon**

Speaker: James Helmsworth, M.D., Cincinnati

3:20-4:00 p.m. **Panel Discussion on Management of Difficult Problems in Coronary Artery Disease —**

Moderator: John Albers, M.D., Cincinnati

Participants: Doctors Georges Daoud, John Flege, James Helmsworth, John Holmes and Ernest Meese.

Art Show Planned
FOR 1972 OSMA ANNUAL MEETING

Space will be provided at the 1972 Annual Meeting of the Ohio State Medical Association, May 9, 10 and 11, at Cincinnati Convention Center for a Physicians' Art Show. The Medi-Art Club of the Academy of Medicine of Cincinnati will merge their annual art exhibit with that of the Ohio State Medical Association at its annual meeting.

Members of OSMA and their wives interested in exhibiting pieces and requiring information regarding this can contact:

Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

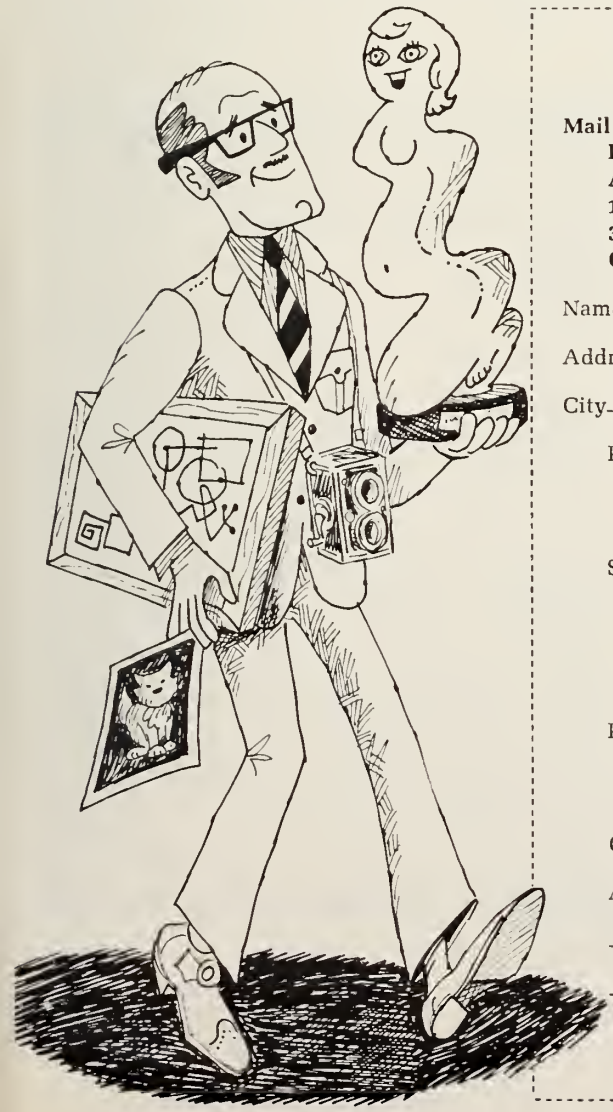
It will be the responsibility of each physician to see that his work gets to the Cincinnati Exposition Center. Final arrangements will be taken care of by a committee.

The OSMA will provide suitable display facilities, but each physician and/or wife is responsible for transportation costs and any other such expenses involved in entering his or her exhibit.

Exhibitors will be limited to two art pieces per person. Please list in order of preference to be exhibited.

An Art Award Committee will judge the exhibit competitively.

We solicit your exhibit to make this an outstanding Art Show.



Application for Space in Art Show Exhibit

Mail to:
Harry H. Fox, M.D., Chairman
Art Show Committee
19 West 8th
368 Doctors Building
Cincinnati, Ohio 45202

Name_____

Address_____

City_____

Photography (must be mounted) _____

_____
(give dimensions)

Sculpture _____

_____
(give estimated size)

Check one: ☐ Pedestal type ☐ Wall type

Painting _____

_____
(give dimensions: depth, width and height)

Other information (which you believe will be helpful to the Art Committee) _____

_____

_____

(Deadline on Art Application to be announced)

How Does Your County Stand in the OMPAC Box Score? Check It!

AS OF MARCH 1 contributors to the Ohio Medical Political Action Committee totaled 1745. That's only a fair showing. This is an Election Year—a very important election year. OMPAC will need plenty of muscle in the form of dollars to give qualified candidates for the Congress and the Legislature the support which they will need in what promises to be knock-down-drag-out campaign battles. Have you contributed? If not, send your $25 to your County Medical Society Secretary for forwarding to OMPAC or send your check directly to OMPAC, P.O. Box 5617, Columbus, Ohio 43221.

—Ohio Medical Political Action Committee

How Counties Stand on OMPAC Membership as of March 1, 1972

First District	OMPAC	OSMA
Adams	3	12
Brown	2	17
Butler	56	204
Clermont	6	19
Clinton	2	21
Hamilton	318	1322
Highland	0	19
Warren	0	15
	387	1629

Second District		
Champaign	0	15
Clark	37	139
Darke	4	24
Greene	0	55
Miami	19	62
Montgomery	200	624
Preble	0	6
Shelby	12	21
	272	946

Third District		
Allen	52	142
Auglaize	0	17
Crawford	16	39
Hancock	10	41
Hardin	4	25
Logan	0	17
Marion	7	67
Mercer	1	19
Seneca	1	42
Van Wert	0	20
Wyandot	1	11
	92	440

Fourth District	OMPAC	OSMA
Defiance	21	29
Fulton	3	16
Henry	0	13
Lucas	18	625
Ottawa	0	21
Paulding	0	8
Putnam	0	11
Sandusky	0	44
Williams	0	20
Wood	11	40
	53	827

Fifth District		
Ashtabula	8	58
Cuyahoga	84	2269
Geauga	11	30
Lake	43	121
	146	2478

Sixth District		
Columbiana	4	73
Mahoning	57	351
Portage	18	58
Stark	105	340
Summit	70	591
Trumbull	0	142
	254	1555

Seventh District		
Belmont	16	59
Carroll	5	9
Coshocton	0	19
Harrison	5	9
Jefferson	10	74
Monroe	0	2
Tuscarawas	14	51
	50	223

Eighth District	OMPAC	OSMA
Athens	3	42
Fairfield	19	53
Guernsey	0	23
Licking	21	71
Morgan	2	4
Muskingum	30	76
Noble	0	2
Perry	0	8
Washington	8	31
	83	310

Ninth District		
Gallia	8	35
Hocking	0	9
Jackson	0	13
Lawrence	14	23
Meigs	0	5
Pike	0	12
Scioto	16	67
Vinton	0	1
	38	165

Tenth District	OMPAC	OSMA
Delaware	5	28
Fayette	2	14
Franklin	149	968
Knox	0	35
Madison	6	16
Morrow	5	7
Pickaway	5	19
Ross	20	40
Union	3	17
	195	1144

Eleventh District		
Ashland	10	27
Erie	26	61
Holmes	5	10
Huron	0	31
Lorain	49	216
Medina	12	60
Richland	45	123
Wayne	27	65
	174	593
Total	1745	10,314

"THE PROFESSIONAL LIABILITY HORIZON"

Thursday, May 11, 1972

Presiding: P. John Robechek, M.D., Cleveland

Moderator: Walter A. Daniel, M.D., Tiffin,
Chairman, OSMA Committee on Insurance

3:00 P.M. Cincinnati Exposition Center
Room 214, Second Floor

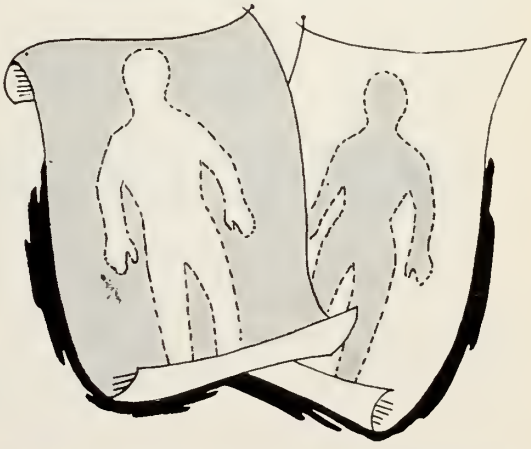
Speaker: Mr. Howard F. Snevel, Director
American Medical Association
Membership and Insurance Benefits Department

Subject: "The AMA'S Approach to Professional Liability Insurance"

3:45 P.M.

Speakers: Mr. James E. Pohlman, J.D.
Legal Counsel, Ohio State Medical Association
Norman O. Rothermich, M.D., Columbus

Subject: "New Patterns of Legal Liability in Physician Patient Relationships"



INSIDE REPORT

Politics 1972

As a supporter of the Ohio Medical Political Action Committee and the American Medical Political Action Committee, you'll want to attend the . . .



ANNUAL OMPAC LUNCHEON

WEDNESDAY, MAY 10, 1972
(week of the OSMA Annual Meeting)

CINCINNATI EXPOSITION CENTER

Speaker...

Washington Columnist and Political Analyst

ROBERT D. NOVAK

Some facts about Mr. Novak...

If you will recall, Mr. Novak was the OMPAC speaker for the 1970 Annual Meeting and by popular demand is returning as our guest speaker at the 1972 OMPAC Luncheon. If you did not hear Mr. Novak in 1970 don't miss attending the 1972 OMPAC Luncheon. A treat will be in store.

In 1957, the Associated Press named him Capitol Hill correspondent in Washington, D.C. He joined the Wall Street Journal in 1958 as Senate correspondent and political reporter, and in 1961 became chief Congressional correspondent for the Journal.

In May 1963, Mr. Novak teamed with Mr. Rowland Evans, Jr. to write INSIDE REPORT, a political column, published five times a week. It is noted for its emphasis on reporting rather than punditry, and its rapidly moving dateline.

OMPAC LUNCHEON RESERVATION

WEDNESDAY, MAY 10, 1972 – 11:30 A.M.

Enclosed is $_____ to pay for:

_____ OMPAC Luncheon tickets @ $5.00 per person

Name:_____

Street Address:_____

City:_____

(Please pick up tickets at OSMA Registration Desk)

Mail to: Ohio State Medical Association, 17 South High Street, Suite 500
Columbus, Ohio 43215

Obituaries

Abraham Arons, M.D., Cleveland; Ohio State University College of Medicine, 1933; aged 62; died February 13; member of OSMA and the American Society of Abdominal Surgeons; practitioner of long standing in Cleveland; served in the Army Medical Corps during World War II.

Wade Disler Bower, M.D., Columbus; Ohio State University College of Medicine, 1925; aged 70; died February 14; member of OSMA, AMA, and American Academy of Family Physicians, of which he was a past president; practitioner of long standing in Columbus.

Edson Jacob Brown, M.D., Chagrin Falls; Western Reserve University School of Medicine, 1919; aged 81; died February 19; member of OSMA and AMA; practitioner of long standing in Chagrin Falls, specializing in surgery.

John Willard Bull, M.D., Marion; University of Illinois College of Medicine, 1927; aged 73; died February 10; member of OSMA and AMA; practitioner for some 42 years in Marion, specializing in internal medicine; veteran of World War I.

Robert Ciekurs, M.D., Lowellville; medical degree from the University of Latvia, 1938; aged 66; died February 2; member of OSMA and former member of AMA; general practitioner in Lowellville; resident of the Lowellville and Youngstown area since the early 1950's.

Walter Coombs Corey, M.D., Chardon; Western Reserve University School of Medicine, 1924; aged 81; died January 30; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in the Chardon area from 1924 until his retirement in 1971; former health commissioner of Geauga County; veteran of World War I.

Arthur H. Corliss, M.D., Dunedin, Florida; Indiana University School of Medicine, 1927; aged 69; died January 20; practiced in Bellefontaine for some three years beginning about 1928.

Joseph Freidinger, M.D., Gallipolis; medical degree from the University of Budapest, 1937; aged 66; died February 16; member of OSMA and the American Thoracic Society; formerly director of Southeast Ohio Tuberculosis Hospital at Nelsonville and more recently associated with the Gallipolis State Institute.

Marion Noville Gibbons Compton, M.D., Cleveland; Western Reserve University School of Medicine, 1925; aged 72; died February 4; member of OSMA, AMA, American Medical Women's Association; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; practitioner of many years standing in Cleveland, specializing in internal medicine; survived by her husband, William C. Compton, M.D.

Basilio Moncayo Gonzalez, M.D., Newark; Faculty of Medicine, University of Valencia, 1951; aged 44; died February 3; member of OSMA and AMA; practitioner in Newark, specializing in ophthalmology; moved to Newark from Cambridge in 1964.

Grant Ostrander Graves, M.D., Columbus; Ohio State University College of Medicine, 1932; aged 67; died February 7; member of OSMA, and AMA; Fellow, American College of Physicians; professor and chairman, OSU Department of Anatomy; past president of the Academy of Medicine of Columbus and Franklin County; practitioner in Columbus for 28 years, specializing in internal medicine; survived by his wife, Helen P. Graves, M.D., practicing physician in Columbus.

Millard Charles Hanson, M.D., Defiance; Rush Medical College, 1923; aged 75; died February 3; member of OSMA and former member of AMA; Defiance County health commissioner since 1966; previously in private practice in Waterbury, Conn., specializing in dermatology; formerly in public health service in Mansfield and in Toledo.

Richard Harris Middleton, M.D., Youngstown; University of Toronto, 1921; aged 75; died January 28; member of OSMA and AMA; fifty-year physician and practitioner in Youngstown since 1928, specializing in pediatrics; served in the Army Medical Corps during World War II.

Robert Evan Miller, M.D., Findlay; University of Wisconsin Medical School, 1937; aged 58; died February 17; member of OSMA, AMA, and American Society of Internal Medicine; diplomate,

American Board of Internal Medicine; past president of the Hancock County Medical Society; practitioner for some 20 years in Findlay, specializing in internal medicine.

John Harrington Mitchell, M.D., Columbus; Ohio State University College of Medicine, 1928; aged 68; died February 11 while in Morocco; member of OSMA, AMA, American Psychiatric Association; Fellow of the American College of Physicians and of the American College of Allergists; clinical professor of medicine at OSU; former treasurer of the Ohio State Medical Association; practitioner in Columbus for about 40 years, specializing in allergy. Dr. William F. Mitchell, also of Columbus, is a brother.

Dean Abbott Nesbit, M.D., Youngstown; Jefferson Medical College of Philadelphia, 1914; aged 82; died February 15; member of OSMA and AMA; general and industrial surgeon of long standing in Youngstown; served in the Army Medical Corps during World War I.

George John Rau, Jr., M.D., Dayton; Loyola University Stritch School of Medicine, 1933; aged 63; died February 7; member of OSMA and AMA; general practitioner for many years in Dayton and team physician for the University of Dayton.

Benjamin Lee Thurston, M.D., Akron; Meharry Medical College School of Medicine, 1923; aged 88; died February 7; member of OSMA and AMA; general practitioner in Akron from 1926 until his retirement in 1967.

Elmer Werner, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 76; died November 24; member of OSMA, AMA, and American Academy of Family Physicians; practitioner of long standing in Cincinnati and director of Health Services for the University of Cincinnati. Dr. Elmer Charles Werner is his son.

Representatives of the Ohio Permanente Medical Group will be present at the Ohio State Medical Association Annual Meeting on May 9, 10, and 11 to discuss available opportunities with that medical group. Representatives may be contacted on these dates by calling Dr. James L. Phillips, Stouffer's Cincinnati Inn, 150 W. Fifth Street, telephone number, 513/721-8600.

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LIPO-NICIN®/100mg.
Each blue tablet contains:
Nicotinic Acid . . . . 100 mg
Niacinamide . . . . . 75 mg
Ascorbic Acid . . . . .150 mg
Thiamine HCl (B-1) . . 25 mg
Riboflavin (B-2) . . . . . 2 mg
Pyridoxine HCl (B-6) . . 10 mg
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

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LIPO-NICIN®/250mg.
Each yellow tablet contains:
Nicotinic Acid . . . . .250 mg.
Niacinamide . . . . . 75 mg.
Ascorbic Acid . . . . . .150 mg
Thiamine HCl (B-1) . . 25 mg.
Riboflavin (B-2) . . . . . 2 mg.
Pyridoxine HCl (B-6) . . 10 mg
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

TIMED RELEASE 6 to 8 HOURS
LIPO-NICIN®/300mg.
Each capsule contains:
Nicotinic Acid . . . . . .300 mg.
Vitamin C (Ascorbic Acid) .150 mg.
Vita B1 (Thiamine HCl) . . 25 mg.
Vitamin B2 (Riboflavin) . . 2 mg.
Pyridoxine HCl (B-6) . . . . 10 mg.
DOSE: 1 to 2 capsules daily.
AVAILABLE: Bottle of 100, 1000.
In a special base so prepared that the active ingredients are released over a period of 6 to 8 hours

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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REFER TO PDR

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

"I can't say enough where the Auxiliary is concerned. . . . it is the strongest voice we in the medical profession have." Those were highly gratifying words to hear, and I heard them a few months ago from the President-Elect of the American Medical Association, Dr. C. A. Hoffman.

THIS REPORTER was fortunate enough to be at "An Evening With C. A. Hoffman, M.D." sponsored by the Scioto County Medical Society to which doctors and their wives had been invited from Southern Ohio, Northern Kentucky and West Virginia. (Dr. Hoffman is a urologist from Huntington, West Virginia.) And I had managed to corner the AMA President-Elect early in the evening to ask how he felt about the Woman's Auxiliary.

He spoke forcefully and favorably (as you can see!) and with unmistakable sincerity. And when I asked him for a special message that I could pass along via this column, he said he would be delighted to give me one. Here it is: "My deep appreciation goes to you members of the Auxiliary for all you have done over the years to support the American Medical Association in its efforts to strive for constant improvement in the delivery of medical care to the people of this country—our patients.

"Your efforts in support of our AMA-ERF movement has, and continues to be, superb. In fact, we of the American Medical Association could not function without you. Continue your work but look for new fields of activity. The physicians of this country need you in our fight for sound health legislation. I know that you will not fail us."

Also present at the "Evening with Dr. Hoffman" was Dr. Oscar Clarke, Ninth District Councilor, and former chairman of the OSMA's Auxiliary Advisory Board. He too had a message for auxiliary members, saying "I would like to extend my best wishes for the auxiliary program and goals. . . . In spite of the fact that I am not on the advisory committee now, I still maintain my interest in the auxiliary and am willing to assist its members in any way."

More on Convention

It always takes two women in particular to bring a convention to life (in addition, of course, to the President, Ann Wiessinger, whose convention it is!). And this year the ingenious cochairmen are Mrs. Robert E. Krone and Mrs. W. B. Wildman II, of Cincinnati. Under their inspired leadership is the core of convention—the dedicated, indefatigable committees full of enthusiasm, ideas and originality. Mrs. Carl Schilling, the 1968 convention chairman, is serving as advisor.

By way of reminder (we have rather detailed accounts on convention in current issues of *The Journal*), the thirty-second annual meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held May 9, 10 and 11 at the Terrace Hilton Hotel in Cincinnati. The State

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

President-Elect
Mrs. L. A. Loria
Box 331, R.D. 1
Bristolville, 44402

Past President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

First Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Second Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

Third Vice-President
Mrs. Karl Ulicny
864 Highland Avenue
Salem, 44460

Recording Secretary
Mrs. Emil L. Barrows
7181 W. Aracoma Drive
Cincinnati, 45237

Corresponding Secretary
Mrs. Robert Holladay
2874 Sands Road
Lima, 45805

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

Board meeting the morning of May 9 and the luncheon following (to both of which the incoming Board members have been invited) will be held in the Skyline Ballroom as will the Mini-Conference for the 1972-73 Presidents and Presidents-Elect that afternoon. Registration all three days of convention will be in the Skyline foyer.

According to my most recent information, the supper at the Medi-Club and the Reds' Ballgame (outlined in last month's issue) is limited to 60 persons. The Night Club Tour (to the Lookout House and Playboy Club) is limited to 50 persons. If you're interested in one of these Tuesday night festivities, get that reservation in! There will also be an art program presented by the OSMA at the Academy of Medicine. After cocktails at 6 p.m. and dinner at 7 p.m., Richard Boyle, curator of paintings at the Cincinnati Art Museum, will speak on "20th Century Paintings." Cost of the dinner is $7. It is suggested that those interested should send a check to Medi-Club, Inc., 320 Broadway, Cincinnati 45202, before May first.

Here's a new note: Closson's of Cincinnati has extended an invitation to all doctors' wives for a "Sherry Hour" at its galleries. This fine store has many outstanding paintings on display as well as completely decorated rooms in all periods. Our members may browse to their hearts' content and enjoy the artistic displays and antiques (they may also purchase any of the unusual items for sale!) The "Sherry Hour" is scheduled for Wednesday, May 10 at 3:30 p.m.

On the Agenda

The first business session comes to order Wednesday morning at 9 a.m.—in the Skyline Ballroom. At noon is the OMPAC luncheon at Convention Center and auxiliary members are urged to attend this most important function. Following the luncheon, it is back to the Terrace Hilton for that traditional and helpful feature, the county presidents' reports. Later that same afternoon, Ann Wiessinger will hostess a reception in her suite for those county officers.

Thursday May 11 (12:30 p.m.) features an "Anniversary Luncheon" honoring the National Treasurer, Mrs. Floyd Anderson (who will be representing the National auxiliary) and Ohio's past presidents. The anniversary emphasis has to do with the forthcoming 50th anniversary of the National Auxiliary in San Francisco. The Cincinnati Choral Group will present a program at the luncheon of "Hits Through the Years", under the direction of Mrs. Charles Sherrick. The morning's breakfast feature will be the "Stop and Swap Hour" described in this column last month.

Ann Wiessinger has chosen as convention theme her 1971-1972 theme of "Let's Paint Ohio RED—RED-icate ourselves, RED-irect our goals, RED-ouble our efforts". Hostesses on the OSMA Boat Ride will be dressed in costumes of the 1895 era and will greet passengers at the gangplank. Table decorations will be styrofoam-shaped riverboats with angel hair smoke rising from their chimneys, tongue-blade paddlewheels and American flags, flying. The little boats will be placed on long blue strips of cellophane simulating water.

Well—there you have it—a bird's-eye view of the doin's, come convention time, May 9, 10 and 11 ("Consult" the Journal's March issue too). It's not the complete picture, by any means—just enough to whet your appetite, so to speak! And get you on the road to Cincinnati come May, when it will be time to stop—and drop in at Sixth Street, between Vine and Race Streets, at the Terrace Hilton. Be seein' you. . . .

Here and There

Franklin County auxiliary's January meeting included a luncheon and tour at the Battelle Memorial Institute. Mrs. Brooks Hurd, president, conducted the business session and passed around sign-up sheets for community service volunteers. Mrs. George Harding III, legislation chairman, presented literature concerning the AMA and the Medicredit Bill. Mrs. Harding urged the group to "make ourselves heard now" and handed out postcards on which to write members of the House Ways and Means committee. Cards written at the meeting were mailed the same day.

The Nominating Committee presented the proposed slate of officers for 1972-73. It was moved that the slate be accepted as presented. Motion passed. Those elected to office for the coming Auxiliary year include: Mrs. Floyd M. Beman, president; Mrs. Donal S. O'Leary, president-elect; Mrs. Samuel Saslaw, vice-president; Mrs. H. C. Bautista, treasurer; Mrs. Donald Lewis, assistant treasurer; Mrs. James M. Coulter, secretary; and Mrs. Horace Davidson, Jr., corresponding secretary.

The January meeting of the **Hamilton County** group featured a talk on "Nepal, Himalayan, Kingdom of Diversity" by Barry C. Bishop, secretary-on-leave, Committee for Research and Exploration, National Geographic Society. The talk was preceded by a social hour and luncheon at the Terrace Hilton Ballroom. Mrs. C. H. Wharton was program chairman; Mrs. Robert A. Matuska, chairman of the day; and Mrs. J. E. Verbryke, chairman of decorations and hostesses. The group's February highlight was a luncheon meeting at the

Schoolhouse Restaurant. Hamilton County past presidents were honored. Sister Jane Kirchner, president of Edgecliff College, discussed "Optimist, Pessimist or Humanist?" Mrs. Max C. Labermeier, Jr., served as program chairman; Mrs. Richard Knoblaugh, chairman of the day; and Mrs. H. Hudson Baumes, chairman of decorations and hostesses.

Speaking of Hamilton past presidents, one of them—Mrs. Joseph Ghory—is the recipient of the years's outstanding service award by the Woman's Committee of the Cincinnati Symphony Orchestra. Nice going . . . and congratulations.

Much Activity

Down **Lucas County** way . . . There was a Midwestern Luncheon and General Meeting on February 8, following which a group of women from the Repertoire Theatre presented dramatic and anecdotal readings entitled "The Seven Ages of Woman". In January, there was a Health Careers Nursing Information Panel in the Academy Auditorium, open to all counselors, health careers club members and other interested persons. A new series of tennis playing lessons for local members began in January at the Racquet Club. The membership aimed its sights on AMA-ERF in March by way of a "pleasurable afternoon of cards, conversation, food and prizes." The fund-raising event was held at the Academy of Medicine building.

And March 18 spotlighted another fund-raising occasion—the annual Aesculapian Ball for the benefit of the Lucas auxiliary's outstanding Mobile Meals program. The dinner dance was held in the Grand Ballroom of the Commodore Perry Motor Inn.

Hospital Gifts

The **Lawrence County** auxiliary contributed the sum of $500 to the Lawrence County General Hospital recently to be used in the continued upgrading of the Health Care Delivery System. Auxiliary members toured the new physical facilities as a part of a special meeting held at the hospital. Among the departments visited were those of Physical Therapy, Laboratory, Surgical Suites, Emergency Room, General Offices, X-Ray, Extended Care Facility, New Delivery Room and other areas which represent the planning and growth indicative of an outstanding modern hospital. Mrs. Thomas Miller, auxiliary president, presented the five hundred dollar contribution to Administrator Dave H. Leasure.

Another gift of money was presented by the **Morrow County** group to the Morrow County Hospital for the purchase of a Monitor Heart Rate Module. Morrow's auxiliary membership of eight doctors' wives plus three dentists' wives made up the hospital's White Twig—a very active and dedicated group of women. Their contribution, like that of Lawrence County, was $500—a fact which tells eloquently what small but determined groups can do! Mrs. Frank Hartsook, treasurer, sent me some interesting facts: "Over the years, we have lent money to a number of girls that they might take nurses' training. We will do it again as soon as we get $400 accumulated. The White Twig helps in the new Gift Shop just started. . . . We wrapped 80 boxes of candy for the doctors at Christmas time, to be given as gifts to the hospital employees. We sold the doctors the candy and made a nice profit on it . . . the district director will visit us in April. The State Presidents have visited our group many times. For a small auxiliary, I think we do many things." You certainly do all of that, Morrow County!

A big salute to Lawrence and Morrow Counties for their generous hospital gifts and outstanding service. (Lawrence County has a membership of 17.)



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Acting Medical Director

G. PAULINE WELLS, R.N.
Admin. Director

HERBERT A. SIHLER, Jr.
President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

"Self-Defense"

The **Trumbull County** auxiliary sponsored an open luncheon and program in February at which Policewoman Jeanne Bray, of the Columbus Police Department, discussed "It Could Happen To You" as well as showing a movie of that title. Mrs. Bray also demonstrated ways to protect oneself from assailants. The Columbus policewoman has spoken before a number of auxiliaries over the state and has been very well received for her practical, common sense approach to self-defense.

There were over 160 women at this community program at the attractive new Y.W.C.A. building in Warren. It was Trumbull County's first experience in presenting a program open to the whole community, and, in the words of the group's publicity chairman, "it turned out to be a worthy experience."

Mrs. B. E. Goodman gave the luncheon invocation. Mrs. K. P. Swisterski, auxiliary president, welcomed the members and guests who included doctors' wives from the sixth district. (The Sixth District meeting at the Trumbull Country Club preceded the luncheon at the Y.W.C.A.) Mrs. Swisterski introduced the out of town guests. Mrs. J. J. Stanislaw, program chairman, introduced the speaker, Mrs. Bray. The table decorations were in the theme of Valentine Day. Those serving on the day's special committees included: Mrs. J. Sudimack, Mrs. M. J. Casale, Mrs. P. G. Zerbi, Mrs. G. R. Musser, Mrs. J. R. McKay, Mrs. D. A. Miller, Mrs. A. M. Ginzler, and Mrs. Stanislaw.

Officers from the State Board and other county officers in the Sixth District attending the district meeting and Jeanne Bray program were: Mrs. Louis Loria, president-elect, state auxiliary; Mrs. William Stephenson of the Columbiana auxiliary; Mrs. Francis J. Waickman, president, Mobile Meals, Summit county; Mrs. Henry Holden, state AMA-ERF treasurer, Mahoning county; Mrs. William Martin, president, Mahoning; Mrs. Robert E. Wirtz, vice-president, Stark county and Mrs. John R. Willoughby, Sixth District director, Trumbull county.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ATHENS (Athens)
Henry G. Croci
Bruce Robert Paxton

BELMONT
G. S. Chawla
Bellaire

COLUMBIANA
Robert E. McArtor
Salem

FULTON
Gerald A. Perkins
Delta

HARDIN
Larry E. Clark
Kenton
Romero B. Mongaya
Biloxi, Miss.

HANCOCK (Findlay)
Edwin B. Davis
Roy E. Hutchison
David Y. Lai
John M. Mertus
Paul E. Moody, Jr.

LICKING
Alfred J. Eckhardt
Newark
John Mark Lowenbergh
Granville
Richard R. Prouty
Newark

LORAIN
Yan S. Liauw
Lorain

LUCAS (Toledo)
Lynn W. Boynton
Robert J. Huss
James A. Jagodzinski
Charles T. Kahle
Leonard C. Mendoza
Ward M. Taylor
David Tullis
John Howard Williams
Metin A. Yuce

MAHONING
Kendall W. Caldwell
Youngstown

MONTGOMERY (Dayton)
Daniel G. Camacho
Parviz Daneshjoo
R. Paul Deenadayalu
Ronald E. Loesch
Luis I. R. Rodriquez-Baz
G. Walter Thein

RICHLAND
Semur P. G. Rajan
Mansfield

TUSCARAWAS
David B. Rulon
Baltic
Keith C. Van Epps
Dover
Benjamin J. Wherley
Dover

WAYNE
Don J. Young
Wooster

WOOD
F. Frederick Householder
Bowling Green

TRAUMA

Tuesday, May 9, 1972
1:30 P.M.
Room 206, Second Floor

Cincinnati Exposition Center

"What's New in Emergency Care"

Program sponsored by the Ohio Committee on Trauma, American College of Surgeons

Panel Program Presentations

Presiding: Wesley Furste, M.D., Columbus, Chairman, Ohio Committee on Trauma, A.C.S.

Moderator: Charles Frey, M.D., Eloise, Michigan

1:30 p.m. Hospital Design—Charles Frey, M.D., Eloise, Michigan; Associate Professor of Surgery, University of Mich.

1:45 p.m. Governor Richard B. Ogilvies' Illinois Statewide Trauma Program—David R. Boyd, M.D., Chicago, Illinois; Assistant Professor of Surgery, The Abraham Lincoln School of Medicine of the University of Illinois College of Medicine. Dr. Boyd has developed an Illinois State Trauma Registry and a state-wide Registry of Emergency Health Services.

2:00 p.m. Postgraduate Training in Emergency Room Medical Care—H. Thomas Blum, M.D., Cincinnati; Medical Director for the Emergency Unit, University of Cincinnati Medical Center.

2:15 p.m. Current Status of Emergency Medical Technician Training and Registry in the U.S.—Mr. Rocco Morando, Columbus; National Director of the Emergency Medical Technician-Ambulance Registry.

2:30 p.m. Recent Accomplishments and Future Plans of the Committee on Trauma of the American College of Surgeons—Thomas W. Morgan, M.D., Gallipolis; Chief, Section V, Committee on Trauma, American College of Surgeons. (Section V includes Ohio, Indiana, Illinois, Michigan, Minnesota and Wisconsin.)

2:45 p.m. Question and Answer Period

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

OHIO, FAIRFIELD, Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

FAMILY PRACTICE RESIDENCY — Just approved — openings at all levels — can start immediately — for details contact: A. J. Pultz, M.D., Chairman, Family Practice Committee, Grant Hospital, 309 E. State, Columbus, Ohio 43215.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

GROUP FAMILY PRACTICE — Excellent opportunity for family practice in pleasant, progressive town near Columbus, Ohio. No OB; well equipped medical center, 5200 sq. ft., including 12 examining rooms, small surgery, own laboratory and x-ray; 3 GP's already in practice; part-time coverage of college health service: modern well equipped 350 bed community hospital with active consulting service and ER group 4 miles from office; excellent local schools. Salary plus percentage first year, leading to partnership. Write to Granville Medical Center, Granville, Ohio 43023.

WANTED: GP, Internist, or Pediatrician, who would like to transmigrate to the practice of allergy. Will teach you. Medical School connections available. Box 647, c/o Ohio State Medical Journal.

PSYCHIATRIC RESIDENCY—modern 120 bed hospital; Akron suburb; near Cleveland; 3 year approved program; area growing; needing psychiatrists; starting salary $13,104; Max Menassa, M.D., Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222. (216) 929-8301.

PHYSICIAN WANTED for Outpatient Service, Cleveland Veterans Administration Hospital, 10701 East Blvd., Cleveland, Ohio 44106. Full or part time; excellent fringe benefits, retirement program. Hospital affiliated with nearby Case Western Reserve University. Allowance for moving expense. Salary depending on qualifications. Non-Discrimination employment. Contact Chief, Outpatient Service, Area Code 216-791-3800, Ext. 265.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

A PRIME OPPORTUNITY — For a General Practitioner in a northwestern Ohio community. New medical building available including an X-ray room and lab. Three modern hospitals within 15 to 20 miles. Complete information relative to this opportunity may be obtained by writing, Ottoville Development Corporation, Box 11, Ottoville, Ohio 45876 or phone 419-453-3610 or 419-453-3756 or 419-453-3120.

POSITION available July, 1972 for Medical House Officer, Hillcrest Hospital. Must have ECFMG. Salary $18,500. Hillcrest Hospital, 6780 Mayfield Road, Cleveland, Ohio. 44124. Please write or call (216) 449-4500, ext. 342.

CIRCLEVILLE, OHIO — 25 miles south of Columbus. Needs physicians, especially General Practice. Population — area of 40,000. New hospital in planning stages. Contact Pickaway County Medical Society, c/o Administrator, Berger Hospital, Circleville, Ohio.

IMMEDIATE OPENING for Internists, Board Certified or Eligible to join five man multi-specialty group in Northeast Ohio. Growing family practice requires two or three new Internists. Excellent location on Lake Erie. New Group Practice Building with lab, X-ray, and physiotherapy facilities. Salary and bonus first two years and full membership thereafter. No initial investment. Good school system, 240 Bed Hospital. Glenn Eippert, M.D., P.O. Box 99, Ashtabula, Ohio 44004.

FOR SALE: Profexray 100-R Tilt-table model; perfect condition; sale due to death. Please call Dr. Edward Jones, (614) 885-4385.

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POSITIONS OPEN: Ohio Department of Mental Hygiene and Correction.

ASSISTANT COMMISSIONER. The psychiatrist chosen for this position must be able to accept program responsibilities as assigned to him by the Commissioner of Mental Hygiene. This includes overall responsibility for a number of state hospitals ranging from small intensive-care facilities to large extended-care hospitals. He also will be required to help develop a growing statewide community mental health program. Individual selected must be a proven leader and mental hospital executive. Salary open.

* * * *

ASSISTANT COMMISSIONER, BUREAU OF DRUG ABUSE. Ohio's drug abuse program, less than two years old, is in need of further expansion and development. This is to take place at the community level, with the Bureau providing a consultative, funding, coordinating role. With the guidance of the Assistant Commissioner and his professional staff, communities will be helped in developing the necessary array of supportive counseling, rehabilitation, and residential services for a full-range program. Obviously this calls for ability, knowledge, experience, and diplomacy. Physician preferred. Salary open.

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SUPERINTENDENT, DAYTON CHILDREN'S PSYCHIATRIC HOSPITAL. This position calls for an unusual psychiatrist-leader who can supervise three separate but integrated programs: that of the 96-bed hospital; the Child Guidance Center of Dayton and Montgomery County, which is housed at the hospital; and a residency training program in child psychiatry. Candidates must be board eligible in child psychiatry. Salary open.

* * * *

For any of the above positions, contact: Dr. Gordon F. Ogram, Assistant Commissioner, Div. of Mental Hygiene, Ohio Department of Mental Hygiene and Correction, 1210 Ohio Departments Building, Columbus, Ohio 43215. (614) 469-3806.

SUPERINTENDENT, BROADVIEW CENTER FOR THE RETARDED, a facility of the Division of Mental Retardation. Broadview Center is unique in that it has been developed as a regional center serving the Cleveland-Cuyahoga County area. The Center is located in suburban Brecksville. Among its services are diagnosis and evaluation, short-term in-patient care for up to 150 patients, 24-hour emergency care, and an active outpatient department. The person chosen must be board eligible in an applicable medical specialty. Salary open. Contact: Dr. Roger M. Gove, Commissioner, Div. of Mental Retardation, Ohio Department of Mental Hygiene and Correction, 1209 Ohio Departments Building, Columbus, Ohio 43215. (614) 469-3813.

OPPORTUNITY FOR GENERAL PRACTITIONER in a small town, N.W. Ohio. Industry, good schools, recreation, modern hospital within 15 minutes. Office for rent or sale by retiring physician. Write Box 644, c/o Ohio State Medical Journal.

PATHOLOGIST available to work for 2 months between April and August, 1972. Highly experienced, American born and trained, now living and working in Israel. Has American citizenship and Ohio State Medical License. If interested call or write: Philip Edlin, M.D., 3010 Burnet Avenue, Cincinnati, Ohio 45219; (513) 961-6366.

WANTED: a physician to join an elderly doctor in general practice. Located in Chillicothe, Ohio in the downtown area. Please contact W. E. Kramer, M.D., 39 W. Main Street, Chillicothe, Ohio 45601 or call (614) 722-2331.

GENERAL PRACTICE rural community of 5000 serving a medical population of 20,000 plus. 50 bed acute hospital and new 68 bed E.C.F. First year guarantee plus furnished office considered. Call collect Charles H. Bair, Adm. Greenfield Municipal Hospital, Greenfield, Ohio 1-513-981-2116 day or 1-513-780-3107 night. Non discrimination in employment.

PHYSICIANS with experience in Internal Medicine or General Practive needed for fully accredited 1000 Bed Psychiatric Hospital located ½ hr. drive from Cleveland or Akron. Ohio Medical License necessary. Contact: Eliere J. Tolan, M.D., Superintendent, Hawthornden State Hospital — Box 305 — Northfield, Ohio 44067. Phone: (216) 467-5663.

MIDDLEAGED G.P., AAFP, excellent health but tired of solo-practice, would like to associate with one or two G.P.s, who have same desire to take time off for extended vacations and study periods. Will eventually relocate. Write Box 645, c/o Ohio State Medical Journal.

BUSY G.P., major city Northeastern Ohio wants associate who could eventually take over practice in near future. Foreign graduate welcome. Give details first letter. Write Box 646, c/o Ohio State Medical Journal.

WANTED: LOCUM TENENS for E.R. for 1-2-3 months in July, August or September. $3,000 plus my own house per month. Opportunity to join group as fifth man is open! Contact: B. Sarihan, M.D., 2501 Marinette Dr., Springfield, O. 45503, Tel: 513-399-7828.

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OPPORTUNITY for advancement with expanding medical staff of 107-bed hospital. Family Practitioners, Board eligible/certified Internists, Ophthalmologists, Surgeons, EENT or Ob-Gyn specialists. Growing community of 20,000. Excellent schools and recreational facilities. New medical clinic adjacent to hospital. Group or private practice available. Ample office space. Send resume to William C. Kelley, Jr., Administrator, Samaritan Hospital, Ashland, Ohio 44805.

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INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

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The antianxiety effectiveness of Librium (chlordiazepoxide HCl) has been demonstrated in more than a decade of varied use. Librium usually provides prompt, dependable relief of mild to severe clinically significant anxiety. It is indicated when reassurance and counseling are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable, appropriate levels.

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Concomitant use: Is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents, diuretics, anticoagulants, anticholinergics and antacids. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide hydrochloride.

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5-mg, 10-mg, 25-mg capsules
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
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MAY • 1972
VOL. 68 NO. 5

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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23 MAY 1972



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The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

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23 MAY 1972

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of

Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety accompanying congestive heart failure

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The Ohio State MEDICAL JOURNAL

VOL. 68 MAY, 1972 No. 5

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"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

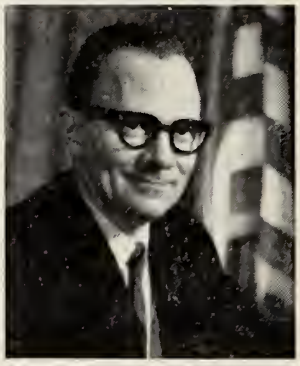
Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of what the medical community *and* federal regulators do will often be represented in simplistic and somewhat misleading terms.

One illustration of the misuse of the media in this regard is the recall of anticoagulant drugs several years ago. This FDA action was given publicity by the press and television that went far beyond its probable importance. The result was a very uncomfortable situation for the practitioner who had patients taking these medications. Since the practitioner and pharmacist had not been informed of the action by the time it was publicized, in most states they were deluged with calls from worried patients.

The practitioner can attempt to solve these problems of inadequate communication in several ways. One would be the creation of a communications line in state pharmacy societies. When drug regulation news is to be announced, the society could immediately distribute a message to every pharmacist in the state. The pharmacist, in turn, could notify the physicians in his local community so that he and the physician could be prepared to answer inquiries from patients. Another approach would be to use professional publications the practitioner receives.

All of this leads back to my opening contention: if drug regulation is to be effective, timely, and related to the realities of clinical practice, a better method of communication and feedback must be developed between the nongovernmental medical and scientific communities and the regulatory agency.

ue

Maker of Medicine

Henry W. Gadsden, Chairman & Chief Executive Officer, Merck & Co., Inc.



In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a law- and regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort by government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

P·M·A

The Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Highway Safety

A Discussion on What the Highway Safety Foundation Is and How It Relates to the Interests of Ohio Physicians

By William Sacks, Executive Director
Highway Safety Foundation

THE HIGHWAY SAFETY FOUNDATION is a private, nonprofit organization, chartered in the State of Ohio. It is independent, having no formal affiliation with government or industry. Our sole purpose is to engage in any activity that will bring about higher levels of highway safety as part of a more efficient land transportation system. The object of our work is not necessarily to attain a zero collision, zero consequence system. It is to evolve a land transportation system as efficient as we have the capabilities to provide.

My purpose is to relate to you a little about our work, not so much to charge physicians with what I might consider to be responsibilities or worthwhile projects, but to give them the opportunity to see where their activities or interests may jive with what we are trying to do. I think it would be somewhat presumptuous of me to say, "you should get involved here," but I think if physicians have an understanding of what we are trying to do, they know their resources better than I do.

The Highway Safety Foundation is basically the financial creation of one man. It has been that way almost to date, although our complexion is changing. In our early years, we were known primarily as the producer of traffic safety motion pictures and education films. The classic films of the day that portray the trauma of highway accidents are our films: "Signal 30," "Mechanized Death," "The Third Greatest Killer," and a host of others.

I won't make any claim for these films except for one thing: They successfully translate the phrase "traffic accident" from something of nebulous meaning to a portrayal of some of the agony and reality of the situation.

The Foundation was formally incorporated in 1960 and the history of the man who started it has some interest. He has no profit motive. He can't travel in air because of his ears, so he has an affinity for land transportation. In the middle 1950's, he lost a friend in an automobile accident. He is an accountant and his way of getting involved meant getting a camera and running out onto the highway, taking black and white pictures of traffic accidents. This is what he knew, and this led to the Highway Patrol learning of him. The Patrol found him out in the field taking pictures and said they would like to have copies for their safety talks. Soon, he was snapping color slides and then the Patrol thought movies would be even better. He purchased a 16mm camera and started making movies.

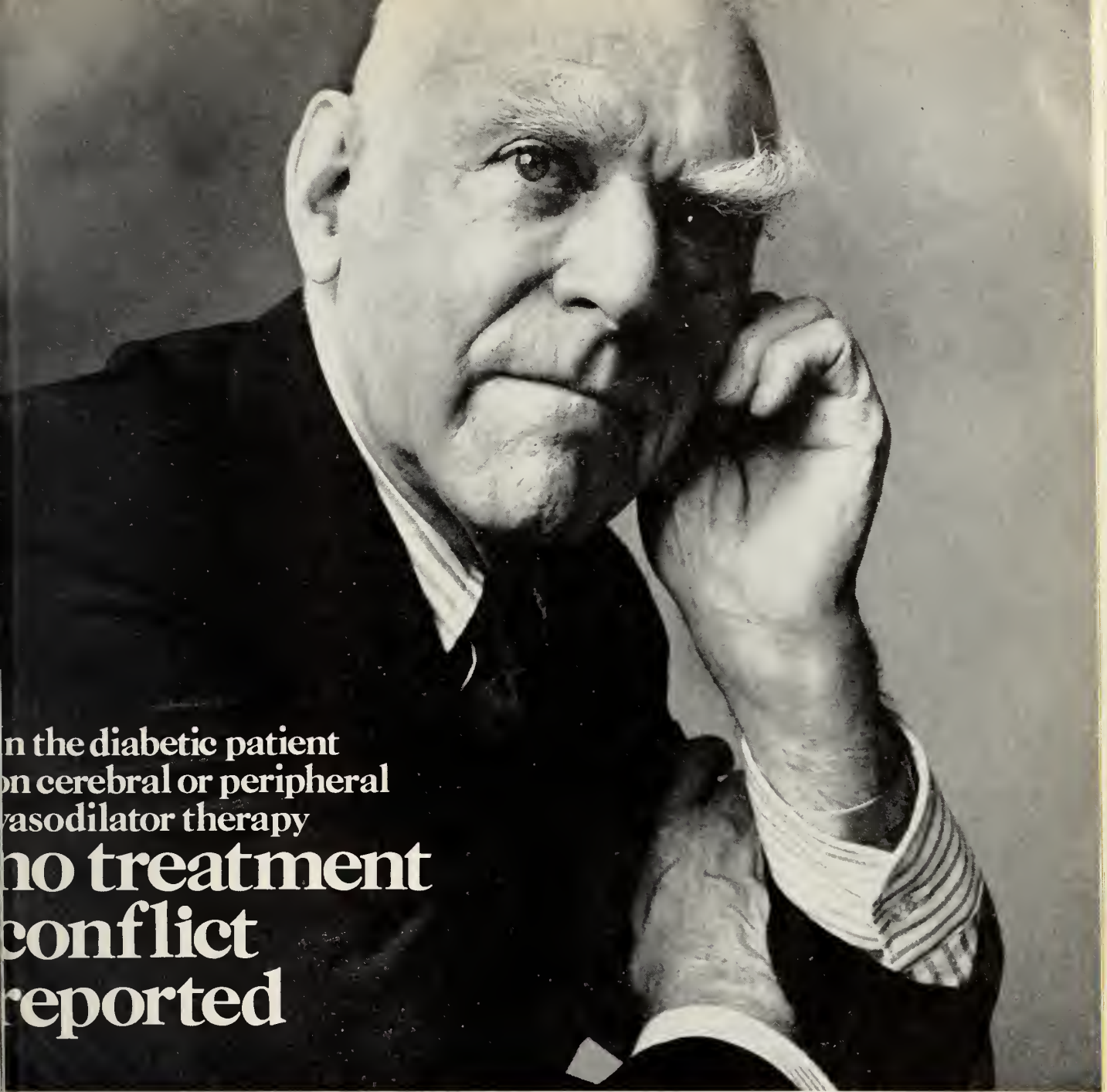
In-Depth Accident Studies

In 1967, the realization came about that not much was known about traffic accidents. In late 1967 and 1968, the Foundation began its program of "multi-disciplinary in-depth accident investigations," a clinical approach. This was when I joined the Foundation. I was previously employed by the Commonwealth of Pennsylvania, in the Highway Department. I was in charge of traffic accidents records and analysis for the Commonwealth of Pennsylvania, and we had a work similarity when I joined them.

The objective of The In-Depth Accident Investigation Program is to provide answers to three questions: (1) causation—what causes traffic accidents? (2) consequences—I don't think any of us would object to an accident situation where there was a zero loss of time, life and resource, and (3) perhaps the most important, what preventive measures, if any, are suggested by these investigations? Three basic questions. The actual obligation of any investigation is found in answers to the first two questions. What brings about the collision and what brings about the consequence of collision. There is no defined obligation to necessarily come up with a cure, although this is obviously what we are looking for.

Over the last two or three years, we have begun to emerge from a very crude art into one

This article is based on a talk given by the author before the Ohio State Medical Association's Committee on Environmental and Public Health, November 17, 1971.



n the diabetic patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported

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- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

lthough not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects isoxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]

dications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), aynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, throm-tic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and autions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of terial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available product brochure from Mead Johnson Laboratories. References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana ed. Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: irr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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that is not so crude. Although traffic accident investigation is still an art, it uses bits and pieces of scientific methodology. It is an extremely complex highway transportation system that we are studying. We are studying the highway transportation system at one of its points of failure. In other words, there is no such thing as a study of traffic accidents. It's a study of the transportation system and we are looking at it at one of its most unfavorable times.

We really don't have anyone on our staff whom I would call an accident expert; I don't think such a thing could exist. I think we have people who understand various disciplines or interactions among the disciplines involved in highway transportation. Some of the disciplines that we employ and use in our team investigations are: highway engineering, traffic engineering, vehicle mechanics, psychology, economics and support disciplines of photography, data processing, law enforcement and police technology, with a host of others, including paramedics. We have a full time paramedic. A fellow who came from Vietnam a few months ago.

Statistics Don't Tell All

We use multidisciplinary as a means of learning something. Sometimes one investigation unto itself will give you an immediate course of action. As an example, we studied a case of a young lady riding a bicycle that was equipped with a headlight designed with only one "D" cell battery to energize the light to make the bicycle visible to the other members of the traffic stream. In this particular case, the father bought the headlight as a means of achieving safety. He checked the battery out regularly and had checked it the day before. We checked the bulb and the battery afterwards and we validated that the battery had 98 percent of rated voltage. The mother was on the second bicycle behind. Long before dusk had set in or twilight began, they stopped and turned on the headlights. These parents did everything any book would tell them to do, but an oncoming car still did not see them and made a left turn in front of the path of the bicycle. The child was struck and seriously injured.

It doesn't take an Einstein to realize that a beam with such low intensity that you can hold the headlight right in front of your eyes and still see the bulb within the parabolic reflector, casts a beam that does not suffice. Furthermore, it doesn't meet state law, which requires a 500 ft. visibility (and I am not saying that this is right) but this single "D" cell light is marketed all over the state today.

I held one of these bicycle lights up in the U.S. House of Representatives, Committee on Public Works, 1½ years ago during the 1970 highway safety hearings, turned down the lights in the conference room and showed the light around. Everyone "ooed" and "ahed" and that was the extent of it. Now, I only bring this case up to illustrate that sometimes a single investigation gives a course of action. I don't need 50 more to know that these one "D" cell powered battery headlights should be taken right off the market, that they are ornaments that are duping parents.

Common Sense Approach

There are times when, in an investigation, the official personnel at the scene (we are not official) do not know what to do. We had a case of a person entrapped in a vehicle. The wrecker which came out from some garage had no extrication tools. The township constable or the part time policeman never saw anything like this in his life. Up to a certain point you observe the system. Once you participate you are disturbing that which you are trying to study. But you have to draw a line. Now it just so happens that a couple of my staff on the scene knew something about extrication, and the use of a crowbar. At this point, our men went in with this crowbar.

"We've learned something here, but we've lost. As an aside, our paramedic, the fellow who has training as would be deemed necessary for this emergency function, has to watch all this pain and suffering and has no way of treating it (as with morphine). This is terrible. This is work which my paramedic did in Vietnam for a year, but you cannot do it here. This is a problem. I bring it up here because I said as I went through you might find areas that might have some meaning to you. Here's one of them. What do we do in this situation? The relief of pain in the field.

We use in-depth investigation for formulating hypotheses. Sometimes we have enough cases in our file (the findings and the objective measurements and data from each investigation) to test hypotheses. (We do reduce our data to a coded format. These are compiling in a computerized file and we are maintaining this on B.F. Goodrich's computer file.)

There come times when an investigation(s) suggests an hypothesis which is so strong and has such promise of feedback benefits, that we actually accelerate the data collection in these particular areas by performing intensive studies within specific perimeters. When we do this, we sacrifice the entire set of observations about an event so that you might have much data for a given circumstance.

We include in our research such things as "defects" in the car mechanism. This word (defects) is the one of the most grossly misunderstood

terms, at least on the basis of our data. For example, in one accelerated data collection process, involving automobile tires, we looked at tires on automobiles that were involved in some 2,717 traffic accidents. There were six tires on six different automobiles at or above legal minimum tire tread depth which incurred precollision deflation for reasons other than puncture or loss of air at the tire rim. There were six tires in 2,717 accidents where the tire "may have failed" due to sidewall crack or anything else, six out of 2,717. Very, very small. In any of these cases the question arises: Was it the tire that failed or was it a misuse? Every tire has a capability inferred in the design. It has limitations of performance and if you put twice as much weight on it and different air pressure, it wasn't meant for this. In any case, we must question whether or not the factor is intrinsically the vehicle or the manifestation of its use and ownership. It is a very complicated field in which we are involved.

Seat Belts—and Their Use

One of our first intensive research projects, we call it part of our related research program, was an investigation of the use and effectiveness of seat belts in traffic accidents. We picked this project because, number one, anyone handling investigations or anyone connected with an emergency room, where we spend a lot of our time, can almost tell you which persons coming in were belted and which ones weren't. Secondly, we saw a latent potential benefit because there are an awful lot of belts and very few users. We felt this to be a good area to research. Even though it is old hat, it has never been capitalized upon. In August of 1969, we began working with the cooperation of the State Highway Patrol, who seem always ready to work with us. Whenever we show them something with potential feedback and value, they are the first ones to respond.

In the one month we sampled 12,000 occupants involved in 4500 traffic crashes in the State of Ohio. We found from our sample a relative risk of incurring death of 4 to 1, unbelted to belted. For in front seat passenger car occupants, we found a relative risk of death without, as opposed to with, use of lap belts as 5 to 1. Serious or disabling injuries as 2 to 1. Rear seat occupants have a lesser difference. As far as use goes, of all the automobile occupants involved in these accidents, approximately 20 percent were using a lap belt. Of all those who had the choice to use or not to use it was in the order of 30 percent. There is a difference, because not every car had seat belts. Approximately 4 percent of the occupants having shoulder belts available were using them at the time of the accident. Unfortunately, the U.S. cars do not exactly afford us what might be called the greatest shoulder belt system in the world. Most people just don't like the shoulder belts. They should be equipped with an inertia reel so you can lean forward. There are many more variables in the consideration for shoulder harness than there are in the lap belt. Height, size, chest and lots of things.

Proposed Legislation

In our case, we differ from what you might call a research organization. We are concerned not only with research but with education, implementation and evaluation. After our seat belt study was completed, we held a press conference in Washington, D.C. and we got some government officials to attend to try to publicize our findings. The following year, in 1970, we started to do some shopping around Columbus to find a sponsor for introducing what is presently House Bill 698 in the Ohio House. This bill calls for the mandatory use of lap belts. The bill is sponsored by Gordon Scherer, Chairman of the House Highways and Transportation Committee. Working together, we got the semblance of a bill, a very simple thing, and this was introduced in April of 1971 as House Bill 698. We were told we would never get out of Reference Committee. The bill is now being heard in the House Highways and Transportation Committee. The Council of the OSMA looked at the bill and decided to support it. The Highway Safety Foundation supports this bill for a number of reasons. Chiefly, it will act to lessen the likelihood of death or injury. Here are some other considerations:

1. **Consumer Investment for Seat Belts** — Since seat belts have been legally required in new automobiles, the American public has invested over $1,000,000,000 for this one item. This amount represents the approximate cost of installing seat belts in more than 40,000,000 new vehicles. This investment has been mandatory, not voluntary.

2. **Current Voluntary Use of Seat Belts** — Studies show that only 32 percent of vehicle occupants having seat belts available are wearing same at the time of accident involvement. As such, about $680,000,000 of the billion dollar investment is being wasted.

3. **The Failure of Advertising Campaigns Promoting Voluntary Use of Seat Belts** — A study of a twelve month, $51,000,000 national advertising campaign toward encouraging the voluntary use of seat belts revealed that the percent of riders using seat belts did not increase. The campaign was a failure. From this study it can be concluded that those people who do not







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No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.



AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur, are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Read the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy





PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3. In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling[2]. T_4 does convert to T_3, though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

Synthroid®
(sodium levothyroxine)

THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

FACTS:
Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

A

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name

Address

City State Zip

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for **Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES INC
Morton Grove, Illinois 60053

yet wear seat belts are not apt to be swayed by additional appeals. Furthermore, it must be realized that public service advertising is not free but is, in fact, paid for by higher charges to other advertisers and, in turn, by the consumer who eventually pays for all advertising.

4. **Public Opinion Concerning Mandatory Seat Belt Use Legislation** — A public opinion survey conducted by the HSF revealed that 58 percent of those interviewed favored mandatory seat belt use legislation, even though the majority admitted that they did not now wear seat belts. Furthermore, this group favored the Bill with no attempt by the interviewer to present the facts and figures contained in this position paper. Of the remaining 42 percent, most all understood the value of seat belts but did not lean toward the mandatory approach.

5. **Seat Belt Use — A Personal or Societal Concern?** — The loss of life and aggravation of injury incurred by those not presently wearing seat belts affects more than the individuals directly involved. The grief is shared by friends and relatives, widows and orphans. The cost, however, may be shared by society through welfare and social security payments but most definitely through higher than needed life, health and automobile insurance costs. That seat belt use is a societal concern is reflected by federal regulations effective this August 1, that require belt use in all interstate trucking and in all civil aviation.

6. **Enforcement of Mandatory Seat Belt Use Legislation** — A survey of many law enforcement agencies and officials indicates no enforcement problems beyond those that may presently exist for requiring a driver's license, requiring the use of corrective lenses, etc. The millions of motorist stops made annually by Ohio law officers affords a convenient means to check for compliance. Most important, the enforcement of any law is predicated on the fact that the large majority of citizens are law abiding. A few months ago, Australia enacted a mandatory seat belt use law. Preliminary studies show that 85 percent of Australians are already complying.

7. **The Nearness of "Passive" Occupant Restraints** — Other techniques such as "airbags," greater interior padding, etc. have been mentioned as alternatives to the seat belt. However, indications are that these devices will not enter mass production until 1975, if at all. Furthermore, because airbags offer no protection in a second impact, as they are to deflate immediately after initial impact, and because airbags do not prevent occupant ejection, the use of seat belts will still be required for full occupant protection. Also, the mechanisms required for reliable airbags infer that they will not be inexpensive; estimates range from $100 to $300 per car, depending on who is asked. Even with the introduction of passive restraints, it will take about ten years before equipped cars filter down to the majority of car owners. Thus, those citizens not able to purchase new cars and who must purchase used vehicles will have to wait several more years beyond the 1975 date. In contrast, the majority of cars now on the road already have seat belts. Perhaps in the future, technology will do away with the need for mandatory seat belt use legislation. If so, good.

8. **Projected Benefits from Mandatory Seat Belt Use Legislation** — A conservative estimate based upon extensive studies is that full compliance will yield to Ohio an annual savings of 1,000 lives and 25,000 serious injuries. These savings far outweigh the financial loss which is apt to be incurred via small fines to those few convicted of violating the law. Obviously, the law abiding citizen can only come out ahead.

9. **The Cost of Alternate Means to Save Lives and Injuries on the Highway** — There are other means by which some portion of the projected benefits may be realized. These include more extensive and effective driver education, building and maintaining safer highways, increased driver testing and reexamination, better emergency medical services, etc. All of these are required, to greater and lesser degrees. However, only House Bill 698 can deliver the projected benefits without increases in government costs. In times of fiscal problems it is hard to ignore a method to achieve a desired result which does not require new expenditures and for which the cost has already been paid or mandated.

The Highway Safety Foundation urges all Ohio physicians to become aware of highway safety problems and to become involved in safety activities if at all possible.

MOVE-OUT STICKY MUCUS..



In asthma, bronchitis . . .

"Many physicians use iodides intravenously when they suspect that the main reason for airway obstruction is sticky mucus but oral iodides are more likely to exert an expectorant action."[1]

"For the viscid sputum, potassium iodide (. . . preferable as enteric coated tablets) may be best."[2]

Provide tastefree, well-tolerated KI in convenient SLOSOL coated tablets–

IODO-NIACIN®

Each SLOSOL coated tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg.

COLE

please see next page for prescribing information–

Promote Productive Cough-



"The productive cough serves the necessary purpose of removing excess mucus from the bronchial tree."[3]

". . . there is clear evidence that the loosening of the bronchial mucus blanket must begin from within the underlying mucus glands where it is anchored and not from the surface. Complications of iodides are too occasional to avoid the use of this valuable medication."[3]

Rx Information:

INDICATIONS: The primary indication for Iodo-Niacin is in any clinical condition where iodide therapy is desired. All of the usual indications for the iodides apply to Iodo-Niacin and include:

RESPIRATORY DISEASE: The use of Iodo-Niacin is indicated whenever an expectorant action is desired to increase the flow of bronchial secretion and thin out tenacious mucus as seen in bronchial asthma, and other chronic pulmonary disease. Iodo-Niacin has also proven of value in sinusitis, bronchitis, bronchiectasis, and other chronic and acute respiratory diseases where the expectorant action of iodide is desired.

THYROID DISEASE: Iodo-Niacin is indicated in any thyroid disorder due to iodine deficiency, such as endemic goiter or hypoplastic goiter, and where hypothyroidism is secondary to iodine deficiency. Iodo-Niacin will suppress mild hyperthyroidism completely, and partially suppress more severe hyperthyroid states. Iodo-Niacin is also of value in suppressing the symptoms of hyperthyroidism and decreasing the size and vascularity of the thyroid gland prior to thyroidectomy.

ARTERIOSCLEROSIS: Iodides have been reported as relieving some of the symptoms associated with arteriosclerosis. The mechanism of action is unknown, but the effects are documented.

OPHTHALMOLOGY: Iodo-Niacin has been reported to be of value in retinal and vitreous hemorrhages. The mechanism of action is unknown, but absorption of the hemorrhagic areas has been observed following use of this drug. It is also reported to be of value in reducing or removing vitreous floaters.

SIDE EFFECTS: Serious adverse side effects from the use of Iodo-Niacin are rare. Mild symptoms of iodism such as metallic taste, skin rash, mucous membrane ulceration, salivary gland swelling, and gastric distress have occurred occasionally. These generally subside promptly when the drug is discontinued. Pulmonary tuberculosis is considered a contraindication to the use of iodides by some authorities, and the drug should be used with caution in such cases. Rare cases of goiter with hypothyroidism have been reported in adults who had taken iodides over a prolonged period of time, and in newborn infants whose mothers had taken iodides for prolonged periods. The signs and symptoms regressed spontaneously after iodides were discontinued. The causal relationship and exact mechanism of action of iodides in this phenomenon are unknown. Appropriate precautions should be followed in pregnancy and in individuals receiving Iodo-Niacin for prolonged periods.

DOSAGE: The oral dose for adults is two tablets after meals taken with a glass of water. For children over eight years, one tablet after meals with water. The dosage should be individualized according to the needs of the patient on long-term therapy.

HOW SUPPLIED: Cole's Iodo-Niacin tablets are available in bottles of 100, 500 and 1,000. Slosol coated pink. NDC 55-6458.

IODO-NIACIN®

Each SLOSOL tablet contains potassium iodide 135 mg. and niacinamide hydroiodide 25 mg. Sig. *ij* tabs. t.i.d. p.c.

References: 1. Itkin, I. H., Am. Fam. Phys. 4:83, 1971. 2. Feinberg, S. M., Consultant Sept., 1971, pg. 32. 3. Bookman, R., Ann. Allerg. 29:367, 1971.

COLE
PHARMACAL CO. INC.
St. Louis, Mo. 63108

Preceptorships Offered to Practicing Physicians

The Continuing Education Program of the Ohio State Regional Medical Program, in cooperation with the Center for Continuing Medical Education of the College of Medicine of Ohio State University and the Ohio Academy of Family Physicians, is offering short Preceptorships for practicing physicians.

The Preceptorships are of one, two or three weeks' duration in the physician's field of interest, and provide an opportunity for the physician to acquire new or refresh present knowledge or skills. The program is structured to allow ample opportunity for free and informal discussion. Preceptorships may be in a single field or in combined fields of interest and are available in most practice areas.

Applicants are asked to state in advance what they wish to learn (educational objectives). This information is submitted to the Preceptor so that the training experience can be individualized as much as possible. The Preceptee subsequently is involved in the evaluation of his experience based upon his original educational objectives.

The Preceptorships have been approved for a minimum of 10 credit hours by the Ohio Academy of Family Physicians, and for a minimum of two days postgraduate credit by the Ohio Osteopathic Association. The Preceptorships are also creditable under Category 4 for the 1972 Physician's Recognition Award.

A tuition is charged, which in addition to course content, includes registration, parking fees, noon meals and library services. The Preceptorship program is open to out-of-state physicians with the stipulation that Ohio physicians will be considered first.

Additional information or application forms may be obtained from: Rose Lee Kennedy, Assistant Director, Continuing Education Program, Ohio State Regional Medical Program, 320 W. 10th Avenue, Columbus, Ohio 43210.

Dr. Hippolit Matuzeski was cited by the Cleveland Society for exemplifying the high principles of the organization. The society promotes good citizenship among persons of Polish ancestry and fosters Polish customs and traditions.

Dr. Austin A. Coulson, McConnelsville, Morgan County coroner, was named president of the Ohio State Coroners' Association at the group's recent annual meeting at Burr Oak.



Internist Organizations Plan Amalgamation

Officials of the American Society of Internal Medicine (ASIM) and the American College of Physicians (ACP) recently recommended to their respective governing bodies that the two organizations be amalgamated providing "the necessary details can be worked out so that equal emphasis will be given to education in the clinical sciences and education in the science of health care delivery."

The Liaison Committee said it believed the final action on the amalgamation can be taken in April 1973 when both organizations have annual meetings in Chicago.

AMA President-Elect Gets Pharmacy Award

Dr. Charles A. Hoffman, President-Elect of the American Medical Association received the Ohio State University College of Pharmacy's Distinguished Alumni Award on March 22. Dr. Hoffman received a B.S. degree from the college in 1925.

After his pharmacy work at OSU Dr. Hoffman operated a retail drug store in Ironton while he continued his medical education at Marshall University, Huntington, and the University of Cincinnati College of Medicine. He received his MD in 1936 and completed his internship and residency at Chesapeake and Ohio Railway Employees Hospital in Huntington, West Virginia, where he is currently chief of urology. Active in both his local community and in organized medicine, Dr. Hoffman is a past president of the West Virginia State Medical Association and the American Urological Association and served as first president of the American Association of Clinical Urologists, which he helped found four years ago.

Dr. Hoffman participated in the seventeenth annual Ohio Pharmaceutical Seminar held March 20-23 at the Pick-Fort Hayes Hotel in Columbus. Sponsored by the OSU College of Pharmacy, the Seminar's title for this year was "The Pharmacist's Role in Drug Product Evaluation." Dr. Hoffman spoke on the topic of Antisubstitution Laws.

Nine million Americans are alcohol abusers and alcoholic individuals, almost ten percent of the Nation's work force, according to an HEW report.

Pre-Sate ®
(chlorphentermine HCl)

CAUTION: Federal law prohibits dispensing without prescription.

Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information available on request.

WC
WARNER-CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

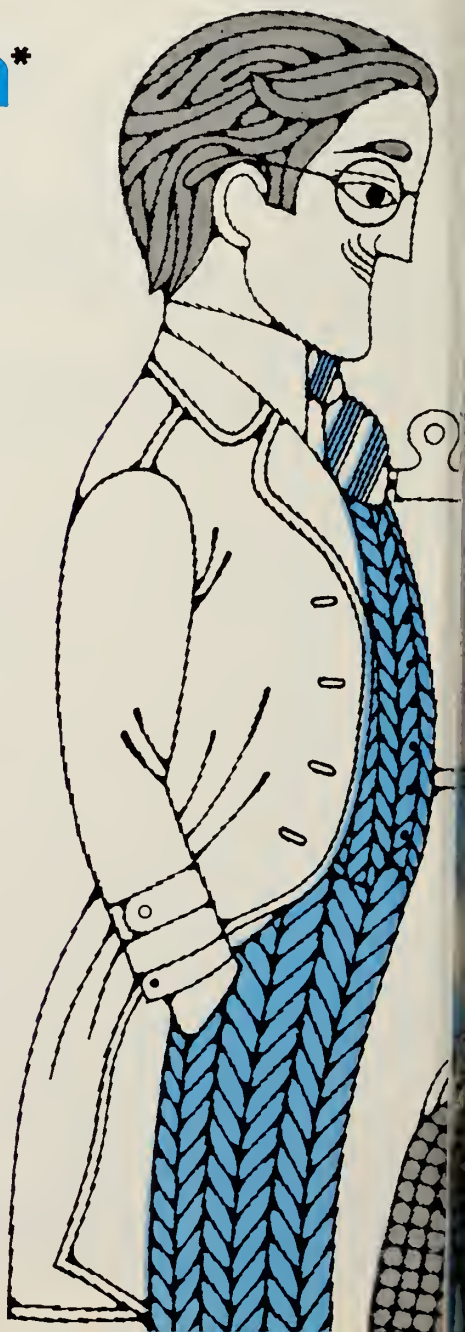


Pre-Sate® (chlorphentermine HCl)...the increasingly practical appetite suppressant

Now available: a total system for obtaining a patient's medical background

The Rocom™ Health History System*

saves time, compiles comprehensive data, aids evaluation



Two new components now make it possible to tailor the ROCOM Health History System to your precise needs. Each item is designed to speed both the collection and review of the complex data you need to make informed decisions.

Patient Data Base System is recommended whenever you schedule a periodic health check-up, or a physical exam for a new patient. The patient completes the comprehensive Health History Questionnaire section before his appointment...your aide enters the results of routine physical measurements and diagnostic tests...and you record the results of your examination quickly and easily on the 18-category physical examination section. Space for a summary of problems and treatment plans is also provided in this single compact folder, which then becomes part of your permanent records.

Branching Health History Questionnaires explore in detail (100-250 questions each) the specific body system in question—Cardiovascular, Gastrointestinal, Respiratory or Ob/Gyn. Each positive answer is automatically transferred to your summary sheet. You begin your review with a complete outline to assist you in determining your diagnosis. Each branching questionnaire contains an abbreviated general background section so that it may be used alone or as an adjunct to any other component in the system.

These new elements, together with the original components, provide you with an optional system for simplified data collection.

Health History Questionnaire can be used instead of the Patient Data Base System when a physical exam has not been scheduled. All pertinent information is covered: family history, past and present illnesses, hospitalizations, immunizations, current medications and known allergies. Current health status is reviewed by 129 carefully chosen questions.

Health History Questionnaire (Spanish) proves invaluable when the patient's knowledge of English is limited. The questions are in Spanish... your summary sheet is in English. The form does the "translating" for you.

*Created and developed by Patient Care Systems, Inc.

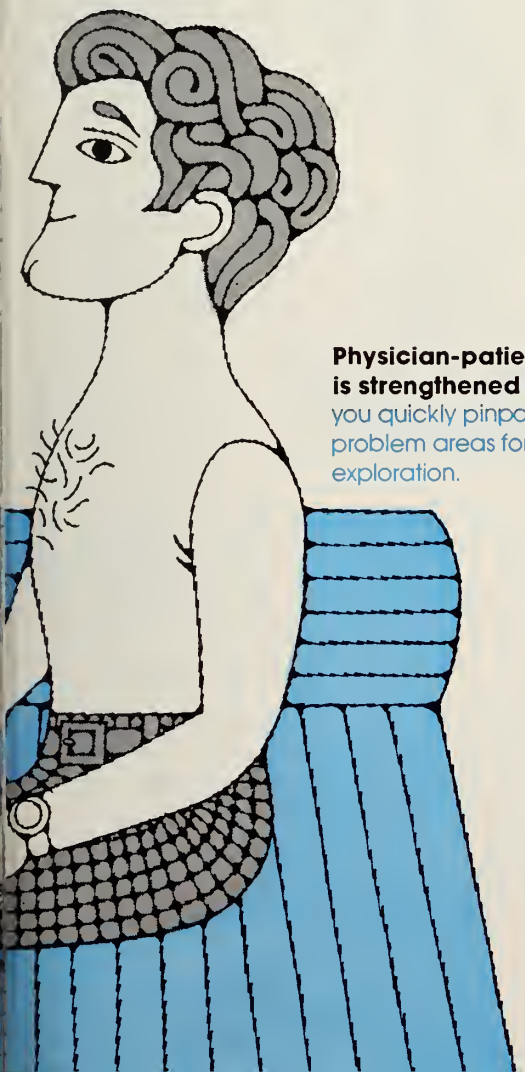


The patient does the time-consuming work before you see him. The questionnaire may be mailed to his home or filled out in your office prior to his appointment.

You get a complete summary at a glance. Only positive answers are transferred, by special pressure-sensitive paper, to your summary sheet. The form speeds review, aids diagnosis, files easily.







Physician-patient rapport is strengthened since you quickly pinpoint problem areas for further exploration.

ROCOM™ Division of Hoffmann-La Roche Inc.
Box 169, Fairview, New Jersey 07022

ROCHE

Gentlemen: I'd like to know more about the Health History System and the other components of the ROCOM Medical Management System: Medical Record System, Patient Health Guides, Telephone System and Appointment System.

Name _____ Specialty _____

Street _____

City _____ State _____ Zip _____

P

MMS - 10H

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Patients should be carefully examined and monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected.

Safety for use in infants, children and pregnant women has not been established.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemo

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

High cure rate:* 96% of 571 males, 95% of 294 females
(Dosages, sites of infection, and criteria for diagnosis and cure are defined below.)**

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

Note: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

*Data compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

globin; hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.
Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiatic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.
Female—single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonarrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Toledo Team Runs Survey on "Telling the Patient"

The controversy goes on. If the patient has a fatal type of cancer, should the doctor tell him of his impending death?

Four researchers centered at the Medical College of Ohio at Toledo say the decision should be based on the patient's own spiritual resources.

But after surveying doctors from four continents, they say the decision usually is based on the physician's own quirks, cultural background and religion—not the patient's.

Their study included 230 doctors: 24 from Argentina, 31 from India and Ceylon, 24 from the Far East, 45 from Israel, 40 American-Jewish doctors, and 66 non-Jewish American doctors.

Each physician responded to a battery of 12 interlocking questions designed to reveal his attitude toward "telling" patients about a fatal disease (cancer), about ordering aggressive treatment for the disease, and about his views on death and immortality.

The investigation turned up significant differences in the medical management of terminal illness. The researchers believe these differences stem from the cultural and religious background of the physicians themselves.

American doctors strongly believe in telling the patient he has a fatal illness; non-Americans strongly oppose this. Argentinians believe in aggressive treatment, even though it "subjects the patient to illness, pain and expense without much benefit to him." Indians and Ceylonese do not favor aggressive treatment; American and Far Easterners would use aggressive treatment only for selective cases; and Israeli doctors were almost evenly split on the question.

Israeli, Far Eastern and Jewish-American doctors give little credence to immortality. The other groups of doctors believe in some form of afterlife.

The Israeli and American-Jewish doctors, the researchers said, "do not believe in preparing spiritually for death, and therefore see no point in telling the cancer patient about his sickness. It is more important for them (the doctors) to prolong life and cause no aggravation or sadness to the patient."

The American-Jewish doctors differed from all others in the belief that man can be happily reconciled to a belief in his nonexistence after death. By contrast, the Indian and Ceylonese doctors strongly believe the patient must have time to prepare for death, but that it is difficult for the patient to cope with the knowledge that his illness will soon be fatal.

The researchers suggest that it is of "utmost importance" for each doctor to be aware of his own particular attitudes about death, so he can prevent these quirks from interfering with the quality of medical care he delivers to the fatally ill patient.

The study was undertaken by Rosalia E. A. Paiva, Ph.D., assistant professor of psychology at the Medical College of Ohio; Isabel R. Juan, Ph.D., visiting professor of psychology at Northwestern University; Jean F. Gagan, M.A., Loyola University, Chicago; and Harold B. Haley, M.D., professor of surgery, Medical College of Ohio.

It was supported by a grant from the U.S. Public Health Service.



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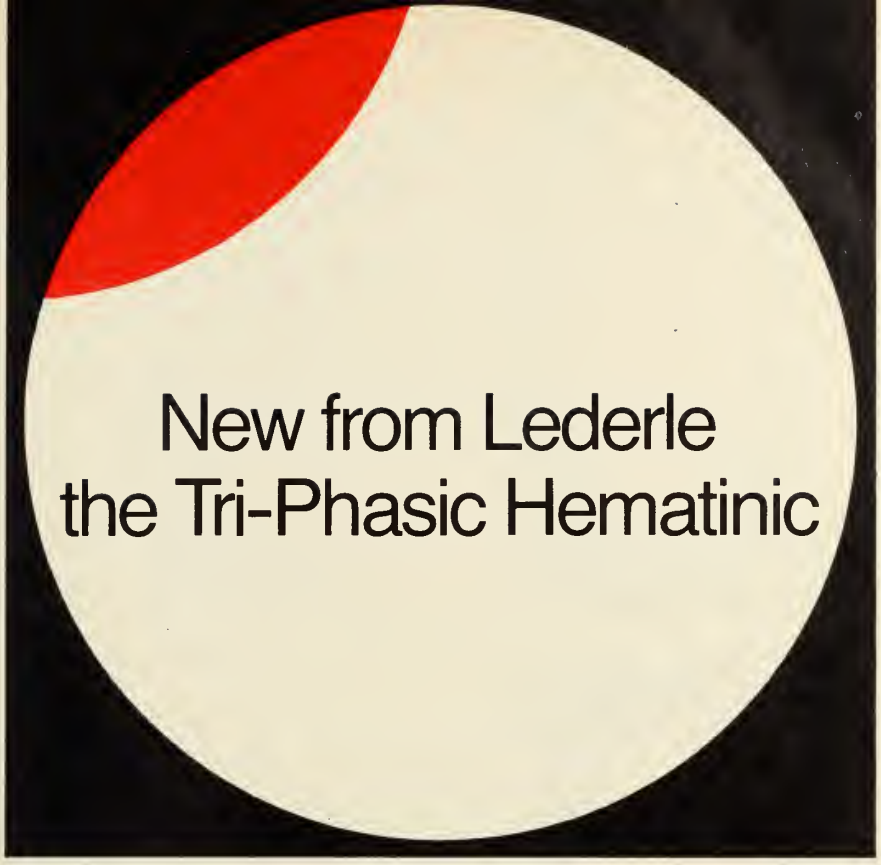
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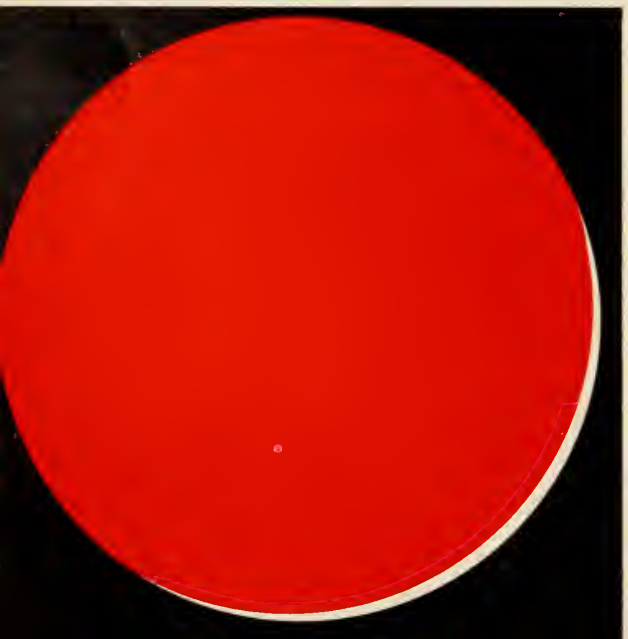
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Adverse Reactions: G.I.: nausea, vomiting, diarrhea, abdominal pain. Skin rashes may occur. Such reactions may necessitate temporary or permanent changes in dosage or usage. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

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A FOURTEEN-DAY Orient Adventure holiday for members of the Ohio State Medical Association has been announced by The Council. Departure date for the trip to Tokyo and Hong Kong is September 15, 1972 from Cleveland and Columbus.

The Ohio State Medical Association has been able to arrange this all-inclusive vacation for just $898 — which is less than regular round trip tourist air fare alone.

This special Orient Adventure price includes chartered round trip jet transportation, deluxe hotels, two meals daily (an American breakfast in your hotel and gourmet dinners at a choice of the finest restaurants in each city), tips, transfers and many other extras to make your trip more enjoyable. The baggage allowance has been increased to 100 pounds, more than adequate allowance for Hong Kong shopping and your golf clubs.

There is absolutely no regimentation on the Orient Adventure. You are free to go where you want, do what you want — when you feel like doing it! You may join in group activities or explore on your own.

A special Orient Adventure escort will travel with you throughout the trip. In Japan and Hong Kong you will have five personable hosts to assist in arranging sightseeing, shopping, golfing, nightclubbing and other activities.

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Tokyo is the world's largest city with a population of twelve million people. This still growing metropolis is a fascinating mixture of temples, towers and palaces. Bustling department stores, as modern as any in the U.S., dramatically contrast with tiny open-front shops. These stores are a shopper's paradise with their woodblock prints, pearls, lacquerware, silk, electronic equipment and, of course, the world renowned Japanese cameras.

There are eleven fine restaurants in the New Otani Hotel. Or choose the best in international cuisine from an outstanding selection of the finest restaurants in the city. A dining must in Tokyo is sukiyaki . . . lightly sauteed vegetables mixed with Japanese Kobe beef, prepared at your table. Part of the fun is eating with chopsticks.

An optional side trip to Kyoto on the famous 130 mile-per-hour Bullet Train places you in a land of the past. Kyoto, capital of feudal Japan, is still the artistic and cultural center of the country. Here are hundreds of gracious traditional Japanese gardens and over two thousand Buddhist Temples and Shinto Shrines.

Then on to Hong Kong, "Pearl of the Orient," for seven days. Hong Kong is a fascinating mixture of British tradition and the intrigue of the Far East. This British Crown Colony is actually two cities — Victoria, on the island of Hong Kong, and Kowloon, on the mainland peninsula. The two are separated by the world's most spectacular harbor. A ferry ride across this bustling waterway offers close-up views of sampans, junks, freighters and luxury liners.

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An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the phys

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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Continuing Education Opportunities for Physicians in Ohio

May

Renal Hypertension Clinic — RMP, University of Pittsburgh — St. Elizabeth Hospital, Youngstown; May 12, 8:00-9:00 a.m.

Family Relations Workshop—Ohio Academy of Family Physicians Continuing Education in Psychiatry project, Toledo Holiday Inn, May 12-14.

Ohio Radiological Society, Scientific Program—Cincinnati, May 12-14 (immediately following OSMA Annual Meeting). Contact Dr. H. Horwitz or Dr. H. Schneider, Department of Radiology, Cincinnati General Hospital, Burnet Ave., Cincinnati 45229.

The Pediatrician's Role in Learning Disabilities—Annual meeting of the Ohio Chapter, American Academy of Pediatrics, May 13-14, at Atwood Lake Lodge, Dellroy. Contact Ohio Chapter, American Academy of Pediatrics, 101 E. Wilson Bridge Road, Worthington 43085.

Flexible Viewing and Photography of the Stomach and Duodenum — Youngstown Hospital Association, South Unit, May 15, 4:00 p.m.; Drs D. B. Brown and S. S. Guleria.

Anorectal Problems for the Generalist — St Elizabeth Hospital, Youngstown; May 19; 8:00-9:00 a.m.; Dr. J. Herald.

Cytochemistry Applied to Hematology — Co-sponsored by the American Society of Clinical Pathologists and the Cleveland Clinic Educational Foundation, at the clinic; May 19-20.

Management of Coronary Occlusion — St. Elizabeth Hospital, Youngstown; May 26, 8:00-9:00 a.m.; Dr. A. Whittaker.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Hepatitis — Subacute Hepatitis, Chronic Active Hepatitis, Needle Hepatitis — Youngstown Hospital Association, South Unit, May 29; Drs. G. A. Butcher and R. S. Arnott.

Fourteenth Annual Refresher Course in Diagnostic Roentgenology — Department of Radiology, University of Cincinnati College of Medicine; Dr. Benjamin Felson, director; May 30-June 3; includes nuclear medicine, radiation physics and radiation therapy; contact Dr. Harold B. Spitz, Department of Radiology, Cincinnati General Hospital, Cincinnati 45229.

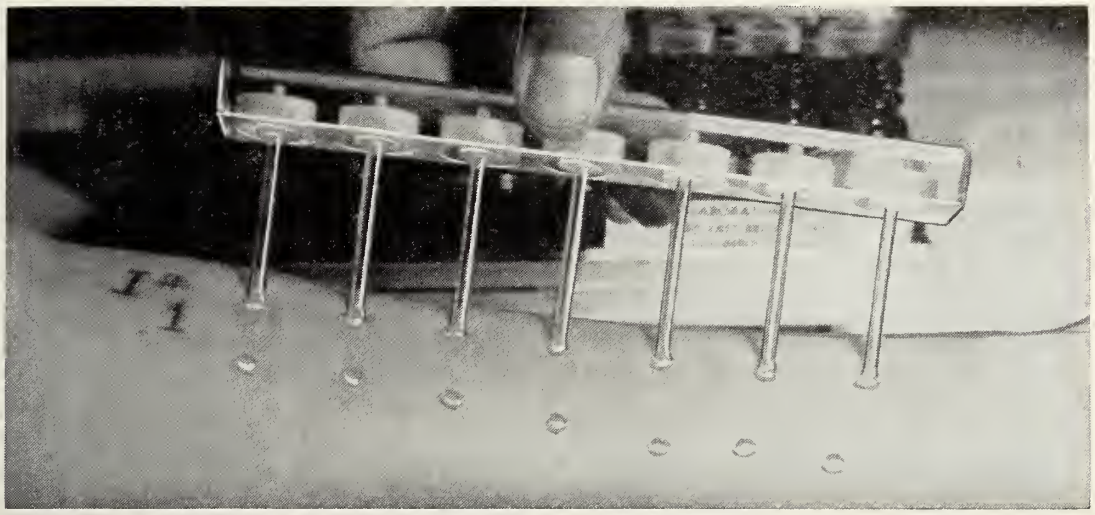
A Practical Approach to Complex Arrhythmias for Cardiovascular Nurse and Physician—Sponsored by the American Heart Association, Eastern Ohio Chapter, at the Ramada Inn, I-80 at Belmont Avenue, Youngstown, May 31-June 1; Contact American Heart Association, Eastern Ohio Chapter, 2516 Market St., Youngstown 44507.

June

Stroke and Rehabilitation — St. Elizabeth Hospital, Youngstown; June 2, 8:00-9:00 a.m.; Drs. R. Gilliland and A. Riberi.

(Continued on Page 466)

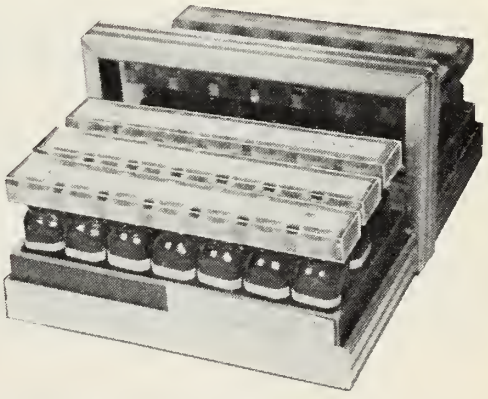
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Educational Opportunities in Ohio — *Continued*

Granulomatous and Nongranulomatous Colitis — Youngstown Hospital Association, South Unit, June 5; Drs. D. B. Brown and Y. P. Sheth.

Symposium on Microneurosurgery — Departments of Neurosurgery, Good Samaritan and Christ Hospitals, Cincinnati, June 8-10; distinguished guest and local faculty; Contact Dr. John M. Tew, Jr., 506 Oak Street, Cincinnati 45219.

Anxiety Reactions and Their Management — St. Elizabeth Hospital, Youngstown; June 9, 8:00-9:00 a.m.; Dr. F. Gelbman.

Modern Concepts in Clinical Cardiology — An American College of Physicians postgraduate course; University of Cincinnati College of Medicine, June 12-16; director, Noble O. Fowler, M.D.; codirector, Robert J. Adolph, M.D.

Management of Hypertension — St. Elizabeth Hospital, Youngstown; June 16, 8:00-9:00 a.m.; Dr. W. Bunn.

Drug Induced Thrombocytopenia and Hemolytic Anemia — Youngstown Hospital Association, South Unit, June 19; Drs. L. M. Pass and N. A. Pappas.

Worms and Man — St. Elizabeth Hospital, Youngstown, June 23, 8:00-9:00 a.m.; Drs. G. Canatsey and P. Van Zandt.

July

Fourth Annual Ohio State Urologic Outing—Subject, "Urologic Infections"; at Avon Inn, Warren, July 31-August 2; contact Chester C. Winter, M.D., Room N—809, University Hospital, Columbus 43210.

August

Fifth Postgraduate Institute for Physicians on Sports Medicine — Sponsored by OSMA, Ohio High School Athletic Association, and the OSU College of Medicine, August 2-3 at the Center for Tomorrow, 2400 Olentangy River Road, Columbus. Contact Center for Continuing Medical Education at Ohio State; registration fee, $30.

Third Annual Short Course on Laser Safety —Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, at the University, August 7-11; tuition, $325. Contact course director, Mr. R. James Rockwell, Jr., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229.

Annual Scientific Assembly, Ohio Academy of Family Physicians—Sheraton-Columbus Hotel, downtown Columbus, August 8-10.

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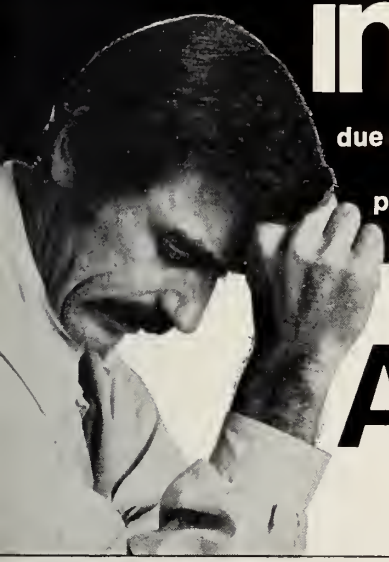
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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Thiamine HCL .....10 mg.
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Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate ..10 mg.
Vitamin B-12 .....2.5 mcg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.
Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Oublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, O. K., and Gallaghor, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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MDs in the News

Dr. William D. Holden, chairman of the Department of Surgery at the Case Western Reserve University School of Medicine and director of surgery at University Hospitals of Cleveland, has been elected president of the American Board of Medical Specialties. Founded in 1933 and reorganized in 1970, the ABMS is composed of 20 primary specialty boards, five subsidiary boards, two conjoint boards, and four associate member organizations.

The Academy of Medicine of Cleveland paid tribute to Dr. Middleton H. Lambright, Jr., expressing regret at his departure from the Cleveland area, and expressing deep appreciation for his contributions to medicine; also wishing him success in his new position. He recently accepted appointment as assistant dean of the University of South Carolina School of Medicine at Charleston. He is a past president of the Cleveland Academy and former member of the OSMA House of Delegates.

Dr. Robert Louviaux, whose painting "Morning Coffee" was featured on the cover of the March 6 issue of *The Journal of the American Medical Association,* is a native of Toledo and a practicing physician there, specializing in obstetrics and gynecology. (See page 1273 of that issue.) The painting won first award in its class at the 1967 Toledo area artists' show.

Dr. Clifford G. Grulee, Jr., dean of the University of Cincinnati College of Medicine, recently participated in a three-week tour of India and attended the 11th annual conference of the Indian Association for the Advancement of Medical Education held at Poona. He represented the Association of American Medical Colleges and the Agency of International Development. He also attended an international meeting of medical students sponsored by the All-India Institute of Medical Sciences in New Delhi.

Dr. Samuel Kaplan, Cincinnati, was elected to a five-year term on the Board of Trustees of the American College of Cardiology at the organization's recent meeting in Chicago.

Dr. Henry Bachman, McConnelsville, president of Southeastern Ohio Health Planning Association board, recently was chosen to serve on the 37-member board of trustees of the American Association for Comprehensive Health Planning at the group's annual meeting in New Orleans.

Dr. Walter A. Hoyt, Jr., of Akron, was elected first vice-president of the American Academy of Orthopaedic Surgeons at the organization's 39th annual meeting in Washington. Under the academy's policy, he will succeed to the presidency for the 1973-1974 term.



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Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.
Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.
Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.
Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.
Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.
Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously receiving narcotics have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Other:* rarely respiratory depression, urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are *not* effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. If naloxone is not available, parenteral administration of the analeptic, methylphenidate (Ritalin®), may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

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the long-range analgesic



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during March. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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Athens

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Hamilton
Garvin H. McClain
Oxford
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Hamilton

CLARK (Springfield)
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Hagop Artin Dikranian
Lorain

MARION
Guillermo V. Crisologo
Marion

MEDINA
Ke-Shiau Chen
Brunswick
Roger Kirkman Smith
Medina

MONTGOMERY (Dayton except as noted)
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G. William Bretz
James H. Davis, Jr.
Herman B. Segal
David G. Small
Centerville

MUSKINGUM
James T. Bishop
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PORTAGE
Pyoung Ki Kim
Ravenna

RICHLAND
William H. Kaye
Mansfield

STARK
Seth W. Brown
Massillon
Francesco G. Nicoletti
East Sparta

A grant from Akron Community Trusts promotes cooperative effort in bioengineering involving the University of Akron's College of Engineering and Akron City Hospital. Engineering students and hospital staff members will direct common effort toward development of equipment such as a portable artificial kidney.

Information, Please, on Allergic Reactions to Bites

The following note was received by *The Journal* with the request that its contents be made known to Ohio physicians:

I am compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, kissing bugs, bed bugs, gnats and flies—including horsefly, sandfly, deerfly. I am also interested in reactions to fire ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the history of the type of reaction and complications if any; the immediate treatment; if desensitization were attempted, and the results.

Send to: Claude A. Frazier, M.D., 4-C Doctors Park, Asheville, N. C. 28801.

Tissue Typing Laboratory Established in Toledo

The Medical College of Ohio at Toledo has opened a tissue typing laboratory to match donors and recipients for potential organ transplants, reportedly the first such facility in northwest Ohio.

After trial runs, laboratory personnel began tissue typing early in March. The laboratory uses the tissue-identification procedure developed by Dr. Paul I. Terasaki, of UCLA, in which a blood sample from the patient undergoes 60 separate test-reactions.

The new tissue laboratory is headed by Dr. Ron Shapiro, assistant professor of medicine, aided by Mr. Thomas Burns, teaching associate. Both took a short course at UCLA last fall, studying the Terasaki procedure.

The Northwest Ohio Kidney Foundation and the Northwest Ohio Regional Medical Program furnished $15,000 toward purchase of equipment and supplies needed to bring the laboratory into operation.

Dr. Hazel Sproull, West Union, was the subject of a feature article in a recent issue of the *Portsmouth Times*. Pioneer as a woman physician in Adams County, she began practice in 1929, first in association with her late father, Dr. O. T. Sproull. "By the time the (Adams County) Hospital was ready for patients she already had delivered more than 2,000 babies in homes," the article states.

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Clinical & Scientific Features



VOLUME 68 MAY 1972 NUMBER 5

Gentamicin in the Treatment of Respiratory Tract Infections

GLENN R. HODGES, M.D., AND SAMUEL SASLAW, M.D., Ph.D.

THE MOUNTING NUMBER of serious infections caused by gram-negative bacilli presents a serious challenge to both patients and physicians. The inherent toxicity of most of the available antibiotics which can be employed in such infections require good clinical judgment in the selection and application of these potent agents. The most recent additions to the armamentarium against infections by gram-negative bacilli is gentamicin, which was first released for general use in 1969. Gentamicin is in the aminoglycoside group of antibiotics and has many chemical, pharmacologic, and biologic similarities to streptomycin, neomycin, paramomycin, and kanamycin. Although gentamicin has a broad antibacterial spectrum of activity against organisms including staphylococci and other gram-positive cocci, its application has been aimed more at gram-negative bacilli, particularly pseudomonas strains.[1] Gentamicin has been shown to be of value in therapy of gram-negative bacteremia[2,3] and urinary tract infections.[4]

Submitted February 17, 1972.

The Authors

• **Dr. Hodges, Columbus, is a Fellow, Division of Infectious Diseases, and Clinical Instructor, Department of Medicine, The Ohio State University College of Medicine.**

• **Dr. Saslaw, Columbus, is Pomerene Professor of Medicine, Professor of Medicine and Microbiology, The Ohio State University College of Medicine; and a member of the Attending Staff, The Ohio State University Hospitals.**

Studies of its efficacy in patients with respiratory tract infections have not been as numerous and results have been less decisive.[5-7] In fact, at the second international symposium on gentamicin, the question was raised as to whether or not gentamicin was effective in pulmonary infection with gram-negative bacteria.[8] It is the purpose of this report to discuss the results observed

with gentamicin therapy in the treatment of respiratory tract infections due to gram-negative bacilli.

Materials and Methods

Twenty-six patients with respiratory tract infections due to gram-negative bacilli were seen and followed by the authors either on the infectious disease ward or in consultation from other services at the Ohio State University Hospitals between June 1970 and July 1971. Prior to and at weekly intervals during therapy the following studies were obtained: sputum culture, complete blood count, serum alkaline phosphatase, serum glutamic oxalacetic and pyruvic transaminases (SGOT and SGPT), serum bilirubin, and urinalysis. Blood urea nitrogen (BUN) and serum creatinine were obtained every third day.

The diagnosis of respiratory tract infection was based on history, physical examination, and supporting radiologic and laboratory studies. The patient had to have a purulent sputum, showing a predominance of gram-negative rods on gram's stain and substantiated by at least one and usually two consecutive, separate sputum cultures. Sensitivities to gentamicin were performed in the clinical bacteriology laboratory employing the Kirby-Bauer single disc technic.[9] All gram-negative organisms isolated from the sputa of patients in this study group were sensitive to gentamicin as determined by the technics utilized.

Response to therapy was monitored by following the clinical, bacteriologic, and radiologic changes during therapy. Prompt and persistent improvement in the symptoms and signs of infection were noted as a clinical cure, lack of improvement as failure. The elimination of the initial infecting organism from the sputum during therapy constituted bacteriologic cure, persistence indicated failure. In the patients with pneumonia, radiologic changes during therapy were recorded as unchanged, improved, or worse as compared to the initial findings.

Results

Clinical evaluation: Seven patients ranging in age from 24 to 78 years (mean, 44 years) had acute illnesses associated with purulent bronchitis and fever (Table 1); five patients had underlying pulmonary disease. The causative agent in every case was a *Pseudomonas* organism alone or with another gram-negative organism. The initial intramuscular dose of gentamicin ranged from 2.0 to 3.0 mg/kg/day (mean, 2.4 mg/kg/day) given in three divided doses. The total dose of gentamicin ranged from 580 mg to 2,050 mg (mean, 1,101 mg). Four patients had clinical cure, two showed some clinical improvement, and one did not respond to therapy. The initial pathogen was eliminated from the sputum in three patients; in the other four, the initial pathogen persisted.

Eleven other patients ranging in age from 28 to 71 years (mean, 60 years) had acute bacterial pneumonia (Table 1); five had underlying pulmonary disease. The most frequently isolated causative organism was a *Pseudomonas* strain alone or in combination with a *Klebsiella* strain. The initial intramuscular dose of gentamicin was 1.8 to 4.6 mg/kg/day (mean, 3.1 mg/kg/day) given in three divided doses. The total dose ranged from 1,140 to 5,840 mg (mean, 2,350 mg). Eight patients had clinical cure of their pneumonia, one had slight improvement, and two did not respond to therapy. There were five bacteriologic cures and seven failures. Radiologic improvement was seen in the eight patients with clinical cures; the patient with slight clinical improvement had radiologic improvement; and radiologic worsening was seen in the two clinical failures.

Eight additional patients ranging in age from 20 to 71 years (mean, 55 years) were treated with gentamicin in combination with a second antibiotic for an acute respiratory tract infection; seven had pneumonia and one had bronchitis (Table 2). Five had underlying pulmonary disease. Again, the most frequently isolated causative organism was *Pseudomonas* alone or in combination with other organisms. The initial intramuscular dose of gentamicin was 1.5 to 4.1 mg/kg/day (mean, 2.9 mg/kg/day) given in three divided doses. The total dose ranged from 900 to 2,690 mg (mean, 1,513 mg). Six of the seven patients with pneumonia and the patient with bronchitis had clinical cure of their infections. The other patient with pneumonia (Table 2, case 22) had recurrence of her infection with *Pseudomonas* ten days after her initial course of therapy was discontinued. There were three bacteriologic cures and four failures. In one patient, case 18, the *Pseudomonas* persisted, but the other initial pathogens were eliminated during therapy. In six of the seven patients with pneumonia where follow-up chest x-ray films were available for comparison, radiologic improvement was clearly evident.

Adverse reactions: Abnormalities of liver function tests were noted in two patients (Table 1, cases 2 and 14) while being treated with gentamicin. Case 2, a 27-year-old man with antecedent staphylococcal pneumonia treated with cephalothin developed *Pseudomonas* tracheobronchitis. At the time of institution of gentamicin therapy, his SGOT and SGPT values were elevated to 79 and 100 units, respectively, and they reached a peak of 110 and 153 units, respectively, on the fifth day of therapy. One week after discontinuing therapy, SGOT and SGPT values were 42 and

TABLE 1. Results of Gentamicin Therapy in Patients with Gram-Negative Respiratory Infections

No.	Age	Sex	Diagnosis	Organism	Underlying Condition	Previous* Antibiotic Therapy	Gentamicin Therapy Initial (mg/kg/day)	Days	Total (mg)	BUN† mg/100ml	Creatinine† mg/100ml	Clinical	Results X-ray	Bacterial
1	78	M	Bronchitis	*Pseudomonas*	Emphysema	C	2.0	7	580	40-63	0.9-1.4	Failure	NA‡	Failure
2	27	M	Bronchitis	*Pseudomonas Klebsiella*	Staph. pneumonia	C	2.4	7	1365	<12	<1.0	Cure	NA	Failure
3	36	F	Bronchitis	*Pseudomonas E. coli*	Rheumatic heart dis.	None	2.8	14	1230	38-24	2.1-1.1	Cure	NA	Cure
4	34	F	Bronchitis	*Pseudomonas Enterobacteriaceae*	Emphysema, bronchiectasis	A,S	3.0	14	2050	<12	<0.9	Slightly better	NA	Failure
5	49	F	Bronchitis	*Pseudomonas*	Chronic sinusitis	A	2.0	8	960	<10	<0.8	Cure	NA	Cure
6	24	F	Bronchitis	*Pseudomonas P. mirabilis*	Hypogammaglobulinemia, bronchiectasis	None	2.8	10	1550	<15	<0.9	Slightly better	NA	Failure
7a	59	M	Bronchitis	*Pseudomonas P. mirabilis*	Emphysema	None	2.0	10	1080	28-53	1.2-3.2	Cure	NA	Cure
7b	59	M	Pneumonia	*Pseudomonas Klebsiella*	Emphysema	C,L	3.3	10	1155	17-114	1.1-4.6	Failure	Worse	Failure
8	69	F	Pneumonia	*Klebsiella Enterobacteriaceae*	Malignant astrocytoma	L	4.6	11	2790	<17	<1.0	Cure	Better	Failure
9	28	F	Pneumonia	*H. parainfluenzae*	None	P	2.6	7	1140	<10	<0.9	Cure	Better	Cure
10	71	M	Pneumonia	*Pseudomonas Klebsiella*	Prostatic hypertrophy	C,K,P	3.9	7	1710	<22	<1.0	Cure	Better	Failure
11	64	F	Pneumonia	*Pseudomonas*	Emphysema	None	3.1	10	1640	<21	<1.6	Cure	Better	Failure
12	61	M	Pneumonia	*Pseudomonas*	Emphysema, rheumatoid arthritis	T	2.8	16	2850	<20	<1.3	Cure	Better	Failure
13	61	M	Pneumonia	*Pseudomonas Klebsiella*	Carcinoma of tongue	T	3.1	21	3150	<24	<0.9	Cure	Better	Cure
14	54	M	Pneumonia	*Pseudomonas Klebsiella*	Cavitary pulmonary histoplasmosis	E	3.7	39	5840	9-30	0.8-1.6	Cure	Better	Failure
15	62	F	Pneumonia	*Klebsiella Enterobacteriaceae*	Stenosis, left mainstem bronchus	P	2.4	12	1155	<17	<1.0	Failure	Worse	Failure
16	64	M	Pneumonia	*Pseudomonas*	Cirrhosis	C	2.8	14	3280	<13	<1.6	Cure	Better	Cure
17	66	M	Pneumonia	*Pseudomonas Klebsiella*	Complete heart block	Cl,S	1.8	9	1170	16-152	0.9-4.0	Cure	Better	Failure

*C=cephalothin, A=ampicillin, S=streptomycin, L=cephaloridine, P=penicillin, K=kanamycin, T=tetracycline, E=erythromycin, Cl=chloramphenicol

†Values were below stated value during and after therapy or, where two values are given, first is value at start of therapy and second is highest or lowest value observed during or after therapy.

‡NA=not applicable

Table 2. Results of Therapy with Gentamicin and Another Antibiotic in Eight Patients with Gram-Negative Respiratory Infections

No.	Age	Sex	Diagnosis	Organism	Underlying Condition	Concurrent* Antibiotic Therapy	Gentamicin Therapy Initial (mg/kg/day)	Gentamicin Therapy Days	Gentamicin Therapy Total (mg)	BUN† mg/100ml	Creatinine† mg/100ml	Clinical	Results X-ray	Bacterial
18	65	M	Bronchitis	*Pseudomonas* *P. mirabilis* *S. aureus*	Emphysema tracheal stenosis	C	2.8	11	1640	<21	<0.8	Cure	NA‡	Failure
19	45	F	Pneumonia	*Pseudomonas*	Bronchiectasis	P	4.1	11	1540	54-4	1.8-0.7	Cure	Better	Failure
20	68	M	Pneumonia	*Klebsiella* *S. epidermidis*	Hyperthyroidism, diabetes mellitus	C	2.6	15	1845	29-11	0.8-1.3	Cure	Better	Cure
21	54	F	Pneumonia	*Pseudomonas*	Emphysema	A	2.4	10	1120	37-18	<0.9	Cure	- -	Failure
22	20	F	Pneumonia	*Pseudomonas*	Bronchiectasis Bronchopleural fistula	C	4.3	24	2690	4.0-39	0.7-2.4	Relapse	Better	Failure
23	70	F	Pneumonia	*Pseudomonas*	Amyotrophic lateral sclerosis	C	2.5	14	1170	33-9	1.4-0.9	Cure	Better	Failure
24	49	M	Pneumonia	*Pseudomonas*	Monoclonal gammopathy	C	1.5	11	900	<18	<1.1	Cure	Better	Cure
25	71	M	Pneumonia	*Pseudomonas* *Enterobacteriaceae* *D. pneumoniae*	Pulmonary tuberculosis, inactive	C	3.0	7	1200	<22	- -	Cure	Better	Cure

*C = cephalothin, P = penicillin, A = ampicillin
†Values were below stated value during and after therapy or, where two values are given first is value at start of therapy and second is highest or lowest value observed during or after therapy.
‡NA = not applicable

102 units, respectively, and they were normal eight weeks after therapy was stopped. The second patient (case 14), a 63-year-old man with cavitary histoplasmosis and *Pseudomonas* superinfection showed significant changes in SGOT, SGPT, and alkaline phosphatase values during the course of therapy with gentamicin and amphotericin-B. In both patients, their disease or potentially hepatotoxic medications received prior to or during the gentamicin therapy could have produced or contributed to these abnormalities.

Two patients developed modest increases in BUN and creatinine while on gentamicin. The first patient (Table 1, case 14), described above, in which increases in BUN and creatinine were noted, was concurrently receiving amphotericin-B, a well-known, potentially nephrotoxic agent. However, the second patient (Table 2, case 22) to manifest renal toxicity had received no potentially nephrotoxic agents before or during gentamicin therapy. At no time did she develop hypotension or decreased urine output. Her initial BUN and creatinine were 4 mg per 100 ml and 0.7 mg per 100 ml, respectively. These increased to 23 mg per 100 ml and 1.6 mg per 100 ml after 11 days of therapy. Although the gentamicin dose was reduced from 210 mg to 40 mg a day, the BUN and creatinine increased further to 38 mg per 100 ml and 2.4 mg per 100 ml, respectively, after three weeks of therapy. Because of clinical and radiologic improvement in her pneumonia, gentamicin therapy was stopped after 24 days. Ten days later, her pneumonia relapsed and she was retreated with gentamicin, 150 mg a day, in combination with carbenicillin. During the three-week course of therapy for the relapse, her BUN and creatinine remained normal.

Three episodes of more severe renal impairment were observed in two patients seen in consultation. The first in this group (Table 1, case 7a) had an initial BUN and creatinine of 28 mg per 100 ml and 1.2 mg per 100 ml, respectively. When therapy was stopped (2 mg/kg/day — total dose 1,080 mg) after nine days, these values were 38 mg per 100 ml and 1.5 mg per 100 ml, respectively, but they increased two weeks later to 53 mg per 100 ml and 3.1 mg per 100 ml, respectively. During his first hospitalization, he had received furosemide, which may contribute to pre-renal azotemia, but he was never hypotensive or oliguric. Four months after his first course of gentamicin, his BUN and creatinine were 17 mg per 100 ml and 1.1 mg per 100 ml, respectively. At this time he received a second course of gentamicin for pneumonia (Table 1, case 7b). His initial dose was 3.3 mg/kg/day. The BUN and creatinine rose progressively, even though the gentamicin dose was reduced (Table 3). Four days after the gentamicin was stopped (total dose 1,155

mg), he died of a digitalis-induced cardiac arrhythmia aggravated by his azotemia. During this hospitalization, he was oliguric, and the day prior to receiving gentamicin, he had received cephaloridine 1.5 gm.

The second patient (Table 1, case 17) to develop severe renal impairment had complete heart block, requiring the implantation of a transvenous pacemaker, and severe pneumonia. Prior to receiving gentamicin, he had received ten days of treatment with streptomycin, and his hospitalization was complicated by severe congestive heart failure, hypotension, and oliguria. Gentamicin at a dose of 1.8 mg/kg/day was administered for nine days (total 1,170 mg). BUN and creatinine

Table 3. Relationship of Gentamicin Therapy to Development of Impaired Renal Function in Case 7b

Day After Start of Gentamicin Therapy	Dose of Gentamicin Daily (mg)	Cumulative (mg)	BUN mg/100ml	Serum Creatinine mg/100ml
1	195	195	17	1.1
2	195	290		
3	195	585		
4	130	715		
5	130	845	27	1.3
6	130	975		
7	45	1020		
8	60	1080	45	2.0
9	60	1140		
10	15	1155		
11	0	1155	115	4.1
12	0	1155		
13	0	1155	114	4.6
14	0	1155		
15	0	1155		Died

were 16 mg per 100 ml and 0.9 mg per 100 ml, respectively, at the institution of therapy and 23 mg per 100 ml and 1.4 mg per 100 ml at the end of therapy, respectively. Seven days after discontinuance of gentamicin, his BUN and creatinine were 68 mg per 100 ml and 6.3 mg per 100 ml, respectively, and 152 mg per 100 ml and 4.0 mg per 100 ml, respectively, 17 days later. Thus, the role of gentamicin in the development of renal failure in this patient is unclear.

Discussion

In vitro, the more resistant gram-negative rods, particularly *Pseudomonas* organisms are usually sensitive to gentamicin. These organisms are becoming more frequently involved in pulmonary infections especially in patients with underlying diseases. In this study, the clinical results were encouraging. Gentamicin was used as the sole antibiotic in treatment of 11 patients with pneumonias due to gram-negative rods; nine were successfully treated, and two were treatment failures. Of seven patients with febrile purulent bronchitis, four were successfully treated, two had slight improvement, and one was considered a treatment failure. An additional seven patients with pneumonia and one with bronchitis were treated with gentamicin and another antibiotic (cephalothin, ampicillin, or penicillin). All but one patient in this group were successfully treated. Although the initial pathogens isolated from this group of patients were sensitive to gentamicin, these organisms were not eliminated from the sputum in 16 cases, despite the fact that clinical improvement was observed in 12 of these patients. This observation has been previously recognized, especially in *Pseudomonas* infections, wherein bacteriologic clearing of sputum rarely accompanies clinical recovery.[10]

The results of therapy in patients with pneumonia reported here are in agreement with two previously reported larger series.[5,6] In our series, the two treatment failures were in patients with underlying pulmonary disease. The greatest failure rate was noted in the series reported by Louria, et al, among patients with underlying pulmonary disease.[6]

The good results in our bronchitis group are in disagreement with a previously reported series of 28 patients in which only six patients benefited from gentamicin therapy.[7]

Although the hepatic dysfunction seen in two patients could not be attributed to gentamicin, an increase in serum transaminase and alkaline phosphatase, with no other indication of hepatic dysfunction, can accompany gentamicin therapy.[11]

There were five episodes of altered renal function among the 26 cases presented; however, in only two was gentamicin the most likely cause of renal impairment. Renal toxicity has been reported to occur in about 2 percent of patients treated with gentamicin.[12] More recently the nephrotoxic potential of gentamicin has been reemphasized and the need for careful monitoring of BUN, creatinine, and creatinine clearance has been stressed.[13]

Damage to the auditory or vestibular divisions of the eighth cranial nerve was not seen in our patients. From early experience with the use of gentamicin, it was noted that renal insufficiency, total doses over one gram, serum concentrations of 12 mcg per ml, age over 60 years, and the previous administration of other ototoxic antibiotics were common characteristics among patients who developed ototoxicity from gentamicin.[14] In a more recent analysis, the incidence of ototoxicity from gentamicin was reported to be about 2 percent.[15]

The usual dose of gentamicin in patients with normal renal function is up to 5 mg/kg/day in

three equally divided doses. The dose used in an individual patient should be adjusted according to the severity of the infection. In patients with underlying renal disease or those who develop impaired renal function while receiving gentamicin, the dose of this antibiotic must be modified accordingly by careful monitoring of renal function. Although guidelines for adjusting the dose in azotemic patients have been published recently,[16] measurement of gentamicin serum concentrations is the only way of knowing the actual drug levels in any given patient because of individual dose-response variations.[17] Peak concentration of 8 mcg per ml are usually adequate, and these should be less than 12 mcg per ml to avoid ototoxicity.

Conclusion

This study suggests that gentamicin alone can be an effective agent in selected gram-negative rod pulmonary infections. As with all aminoglycoside antibiotics, it should not be used indiscriminately. Combining good clinical judgment and proper monitoring of its potential side effects in reference to renal and eighth nerve function, the increasing number of troublesome gram-negative infections, particularly those due to *Pseudomonas,* may be better controlled.

Acknowledgement: This study was supported by grants from the Schering Corporation, Bloomfield, N.J., and the National Institute of Allergy and Infectious Disease (special research Grant 5F03-AI-48, 323-02).

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 2-year-old boy is brought to the emergency room after his mother found him playing with a caustic oven cleaner.

Findings from the general examination are normal. There are no burns on his lips or oral cavity. He is in no distress and does not drool.

What should be your next step?

(See p. 495 of this issue for further information and discussion.)

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Submitted August 2, 1971.

Drug Use by Ohio Adolescents

An Epidemiologic Study

R. Dean Coddington, M.D., and Robert Jacobsen, B.Sc.

MANY ARTICLES on the extent of drug use by high school and college students have appeared in lay publications; and estimates or guesses, of the magnitude of the problem have been broadcast across the land. Definitions of terms rarely appear in such articles, and for the most part the adult population generalizes their concern by associating all adolescents with drugs. Physicians are called upon to participate in crash programs to educate youths, but they often find themselves with no more factual information than that available to the public. It is the purpose of this paper to report a survey of over 5,000 young people, and to describe as specifically as possible the pattern as well as the extent of drug use among the subjects.

Method

In the course of another study, questionnaires were distributed throughout several areas in Ohio in order to obtain a representative sample of the youthful population. The questionnaires were presented to junior high and high school students by other students and collected anonymously. For the most part, the school authorities did not participate in the study except to grant permission. A sample of undergraduate college students, some medical students, and some adolescents in the Juvenile Diagnostic Center (Columbus, Ohio) were included. Of the 5,318 completed forms, 5,299 were complete enough for the analysis of data.

With respect to drugs, the subjects were asked whether or not they had used alcohol, marijuana, methedrine, LSD-25, other hallucinogens, or heroin; and if so, had they used it from one to six times or more than six times. Some colloquial and slang synonyms for the drugs were also used to avoid misunderstandings. Although a rare subject indicated that he used every drug more than six times, suggesting an invalid response, inspection of the majority of responses seemed to indicate a high level of cooperation and honesty. All completed forms were included in the analysis.

Analysis of the demographic data indicates a fair degree of success in sampling the population. Half of the subjects were male, half female. The white-to-negro ratio was 80/20 compared to 88/12 for the entire state. In our sample, 32 percent were classed as urban dwellers (ie, spent most of the last ten years in an urban area) and 28 percent were rural. This compares to 38 percent of the state population that lives in cities of over 50,000 people, and 23 percent who live in rural counties. (Figures are based on 1969 population statistics). The age distribution is indicated in the figures above each bar (Figs. 1-6); the reader is cautioned to note the relatively small number at both extremes. The religious distribution is shown in Table 1. There were 415 members of the highest socio-economic class (Hollings-

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This project was initiated in partial fulfillment of class assignments of the Department of Pharmacology at The Ohio State University, Columbus, Ohio.
Submitted August 18, 1971.

ead's social Class I), 474 in Class II, 1063 in Class III, 1951 in Class IV, and 824 in Class V (572 unclassified).

Results

Figures 1 through 6 indicate the extent of drug usage plotted against age. The smoothness of the curves of alcohol and marijuana use attest to the honesty of the respondents. One sees that the use of these two drugs increases with age,

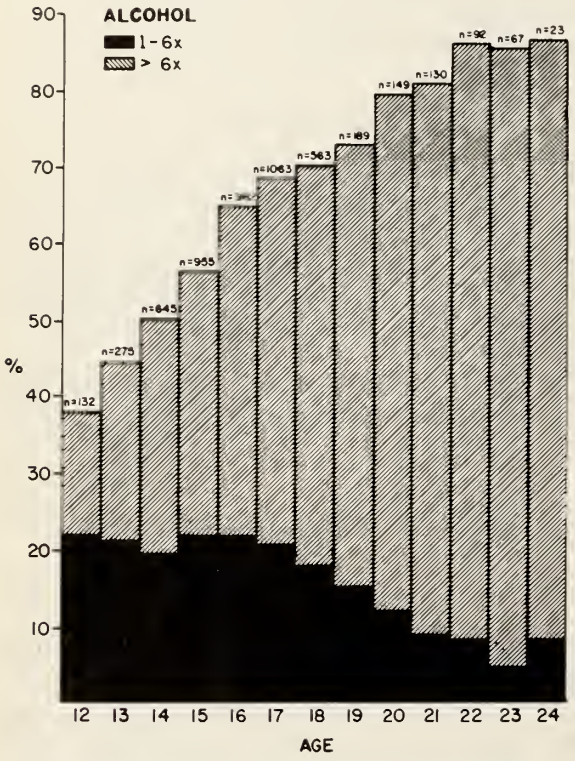


Fig. 1. Percent of respondents who have used alcohol.

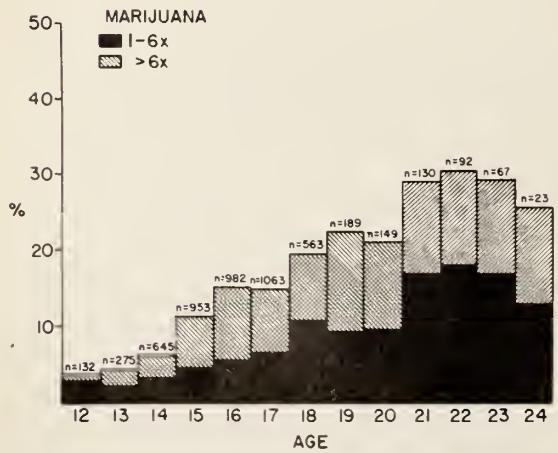


Fig. 2. Percent of respondents who have used marijuana.

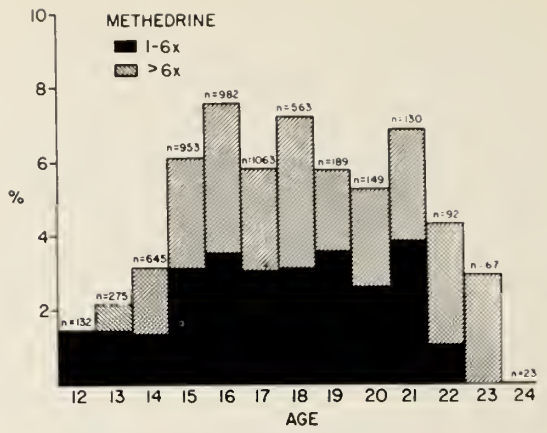


Fig. 3. Percent of respondents who have used methedrine.

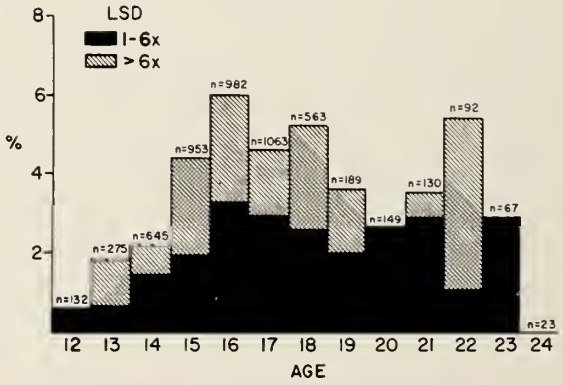


Fig. 4. Percent of respondents who have used LSD-25.

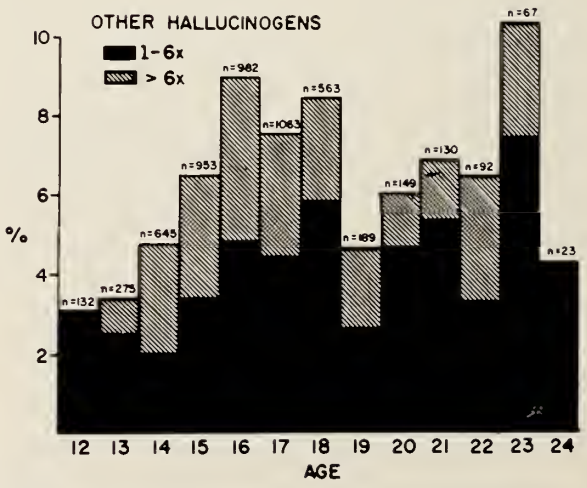


Fig. 5. Percent of respondents who have used hallucinogens other than LSD-25.

leveling off during the college years. The use of other drugs is not related to age, but is a more individualized act. The peak incidence of heroin usage in this survey is at age 16 years.

Table 1 gives the data regarding the variables of sex, race, place of residence, and religion. There is a consistently greater use of all drugs by boys. Blacks use less alcohol but more of all other drugs than do whites, but the total drug use is about the same. This difference probably reflects the availability of drugs rather than a racial pattern. The data regarding the subject's residence bears this out; there is much similarity between urban and suburban youths, while the largely white rural population has not yet felt the impact of drugs.

Two factors came to light when examining the data on religion. Catholics use less marijuana, while Jews use more than either Catholics or Protestants. A consistent finding is the greater use of all drugs by those respondents that didn't identify themselves with any religion. It would appear that mere affiliation with a religion tends to inhibit the use of drugs, for some respondents indicated that they were only mildly involved with their preferred religion.

The data were sorted and re-sorted in order to discover the patterns of drug use, particularly multiple use in some cases, and abstinence or "experimental" use by other subjects. These data are presented in Figure 7 and Table 2.

Half of the junior high school students and 30 percent of high school youths deny the use of any drug, even alcohol, at any time. A large group

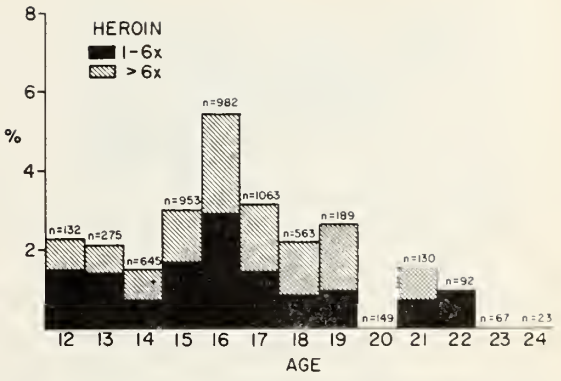


Fig. 6. Percent of respondents who have used heroin.

have used alcohol which, judging from the widespread use at age 12 years, is introduced to him at home. We see then that 90 to 95 percent of junior high students and 80 percent of the high school group have had no experience with a drug other than alcohol. Dangerous drugs were reported to be used once or more by less than 20 percent of the adolescent population.

In Table 2 the data regarding multiple drug use is presented by focusing on those that used at least one drug more than six times. The number of these subjects (a) that used a second drug more than six times; (b) that used other drugs less than six times; and (c) the percentage that deny using another drug, is recorded. In the case of marijuana, a large number of users (about 50

Table 1. Percent of Subjects Using Drug More Than Six Times by Sex, Color, Residence, and Religion

	Sex		Color		Residence*			Religion			
Number	Male 2660	Female 2595	White 4106	Black 997	Urban 1674	Suburban 2071	Rural 1461	Catholic 1494	Protestant 2140	Jewish 440	None** 1121
Alcohol	54.10	32.80	45.45	35.40	38.90	47.80	43.40	48.06	37.57	44.32	49.06
Marijuana	9.67	5.28	6.62	10.84	8.37	10.90	1.58	2.54	6.07	11.82	13.20
Methedrine	3.45	2.08	2.38	3.92	3.53	3.62	0.62	1.20	2.38	0.45	5.33
LSD-25	2.29	1.50	1.77	2.51	2.15	2.17	0.62	0.80	1.59	0.68	3.48
Other hallucinogens	3.76	1.97	2.31	5.12	4.36	3.19	0.62	1.07	2.80	1.36	5.17
Heroin	2.29	1.00	0.88	3.92	2.09	1.30	0.82	0.53	1.45	0.68	2.77

*Indicates type of community in which respondent spent most of the last ten years.
**Includes responses of "none" plus those where no indication was given. Excludes "other" religions.

Table 2. Patterns of Drug Use

Drug A Number Using Drug More Than Six Times		Drug B Percent Using Another Drug More Than Six Times					Percent Using Another Drug or Drugs One to Six Times	Percent That Never Used Another Drug
		Marijuana	Methedrine	LSD-25	Other Halluc.	Heroin		
Marijuana	397	——	29.2	22.2	29.2	14.9	23.2	26.7
Methedrine	149	77.8	——	47.0	52.3	31.5	8.7	3.4
LSD-25	101	87.1	69.3	——	61.4	42.6	3.0	1.0
Other halluc.	152	76.3	51.3	40.8	——	27.6	2.6	8.6
Heroin	78	75.6	60.3	55.1	53.8	——	3.8	10.3

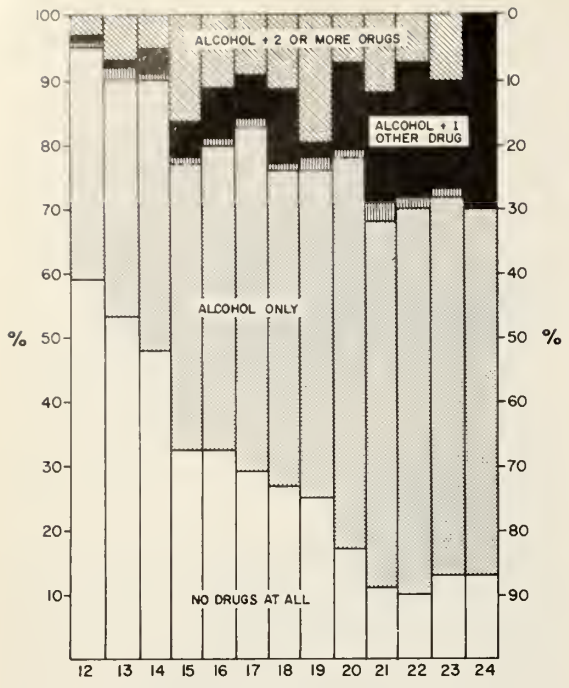


Fig. 7. Percent of respondents who have used no drugs at all, alcohol only, one drug but not alcohol, alcohol plus one other drug, and alcohol plus two or more other drugs.

percent) never became involved with other drugs. On the other hand, a very large number of those that use other drugs also use marijuana. If the subject has used methedrine, hallucinogens, or heroin more than six times, he has almost certainly used a second or third drug too.

Discussion

We have attempted to show that a fairly small percentage of adolescents account for most of the illicit drug use in their society and that the vast majority of youngsters use no drugs at all or stick to the drug their parents use, namely alcohol.

How many teenagers are actually involved? If we apply the rates determined in this study to the school population of Franklin County and of the State of Ohio, we discover that 5,000 junior high and high school students in Franklin County have used alcohol plus two or more other drugs at least once. The figure is about 86,000 for the state as a whole. This begins to look like a significant public health problem requiring early case finding and educational as well as therapeutic programs.

Table 3. Estimated Number of Cases of Heroin Addiction in Franklin County, and the State of Ohio.

Age	Population	Heroin Use: At Least Once Rate (%)	At Least Once Cases	Heroin Use: More Than Six Times Rate (%)	More Than Six Times Cases
Franklin County					
12-14	34,539	1.805	623	0.753	260
15-17	28,827	3.910	1,127	1.899	547
Total	63,366		1,750		807
State of Ohio					
12-14	542,309	1.805	9,760	0.753	4,080
15-17	476,163	3.910	18,600	1.899	9,200
Total	1,018,472		28,360		13,280

Some might argue that most of these children fall into the category of a social or public health problem rather than being the responsibility of the practicing physician. We concur to a certain degree, but some of these are clearly medical problems. Let's look at heroin, for instance. Although adolescents claim they can "dip and dab" with heroin, using it once a week while avoiding addiction, the authors feel that any teenager who has used it more than six times is probably addicted; he certainly needs good medical and/or psychiatric care.

Table 3 shows us that we have by this definition 800 adolescent heroin addicts in Franklin County, and more than 13,000 in the state. An additional 28,000 junior high and high school youths are playing with fire and may now be addicted.

Summary

This paper describes a survey of 5,299 Ohio youths that are representative of the Ohio population in terms of sex, race, socio-economic class, place of residence, and religion. Most of the drug abuse that occurs is accounted for by about 20 percent of the adolescent population; and adolescents as a whole should not be condemned as a rebellious subculture. Nevertheless, we do have a major health problem which requires the attention of Ohio's physicians.

See editorial comments on page 491.

Water Quality and Community Health

Bailus Walker, Jr., M.P.H.; Jesse Ortiz, Dr.P.H.; and
E. Frank Ellis, M.D., M.P.H.

IN LATE JUNE OF 1971, "breakdowns" at Cleveland's Easterly sewage treatment facilities resulted in the daily discharge of approximately 120 million gallons of raw sewage into Lake Erie.

It required no great prescience to tell that this additional organic load on an already "stressed" body of water would generate public concern about potential health hazards to communities located on the central basin of the Lake, and it also raised questions as to the capacity of the Lake to assimilate this waste without further deterioration of the bioecology of an aquatic ecosystem.

During the same period, the Red Bank, New Jersey police closed that borough's beaches along the six-mile-long Navesink River "because of pollution;" and 25 miles farther south, health officials were keeping close tabs on the four-mile-long Metedeconk River which flows into Barnegat Bay. One New Jersey state official said vacationers along the Metedeconk are "literally swimming and boating in their own sewage."

In Mediterranean land, the National Federation of Bathing Beaches reported that all of the 6,000 registered beaches on that historic sea are "dangerously polluted," if the standards decreed by the Health Ministry are recognized. The Ministry set a standard of "100 bacterial molecules for every 100 cubic centimeters of water," as compared to French standards of "500 molecules per cc."

The Rome newspaper *Giornale d'Italia* reported last August that a number of beaches off Genoa, Naples, and Salerno have pollution counts 100 times higher than the Ministry Standards; some were closed to recreational activities.

Earlier this year the U.S. Public Health Service reported that millions of Americans were drinking water of hazardous or inferior quality.[1] However, it was found that the larger systems, such as those in Cincinnati and Cleveland, were delivering "mostly good water." In fact, many of the "deficiencies" cited in the report were deficiencies of procedure rather than deficiencies in water quality served.

Currently, scientists are attempting to prove to their own satisfaction whether or not pollution damages the environment, while others are urging improvements in municipal waste treatment facilities rather than modification of detergents as the answer to phosphate pollution. With an equal degree of concern, physiologists are questioning the new guidelines for mercury when very little is known about how it is absorbed or eliminated in higher animals.

In Suffolk County, New York last March, the sale of detergents was banned because of water pollution; and in Michigan, the ban on sport fishing in Lake St. Clair, where the mercury excitement started, was declared unconstitutional,

Submitted September 9, 1971.

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• Dr. Ellis, formerly Director of Public Health and Welfare, City of Cleveland, is presently Regional Health Director, Region V, U. S. Department of Health, Education, and Welfare, Chicago.

settling not the scientific but the legal question. From England, a recent editorial in the *British Medical Journal*[2] concluded that we can object to pollution of coastal waters only on esthetic grounds because there is "—— no epidemiological evidence that sewage-contaminated sea water is a real risk to health."

Today, a growing segment of the American public is disenchanted with progress in water pollution abatement, not because it questions the legitimacy of current scientific and technical efforts but because it questions the value of the end results in terms of a safe and wholesome community water supply. This disenchantment sometimes takes the rhetorical form: we can land a man on the moon but we can't resolve the problem of understaffing, underfunding, and lack of visible progress of water pollution control programs.

There are numerous issues in the water quality maintenance programs: some are old, some are new. Planning, financing, and coordination of water resources development are a few of the new issues, while the old ones of chemical and bacteriologic standards, health considerations, and the need for new legislation are still around. Certainly, the whole list of issues affords ample opportunity for scientific, engineering, social, or political debate. But the responsibility for water quality surveillance rests mainly with water hygiene specialists, including environmental engineers and public health sanitarians. However, private medical practitioners and public health physicians have long been concerned about the effects of water quality on human health. Indeed, the history of waterborne disease is replete with instances of individual practitioners making significant contributions to water quality improvements based on careful clinical and epidemiologic observations.

Few students of epidemiology can forget that John Snow, Queen Victoria's physician, first recognized the importance of water as a carrier of the London cholera epidemic of 1894. Snow noted that populations supplied water by different companies suffered different mortality rates. One particular water source, the Broad Street pump, accounted for almost all cases of cholera. So, late one night he went to Broad Street and removed the pump handle, thereby stopping the epidemic.

Medical historians now suggest that this act by Dr. Snow perhaps redefined the "role" of the physician in community health services and "created" the field of public health.

Even today, when the debate is focused sharply on the best approach to an economic health care system, medical practitioners are being called on for advice regarding water quality, not only from the narrow viewpoint of personal and community health but with equal concern for conservation and industrial-use aspects.

Thus, it is the purpose of this presentation to attempt to summarize the relevant information on water quality and community health and provide selected references necessary for an informed judgment on the subject.

Health Considerations

While accomplishments in the Western World have lowered the morbidity and mortality rates of waterborne diseases, approximately two thirds of the globe's population is still under serious threats to health via unsafe and inadequate water supplies. In this century, cholera has appeared in India, Ceylon, Iran, Vietnam, and China. As late as July 1971, the hardly *El Tor* strain of cholera made a new advance across Asia, Europe, and Africa from the beginning of its most recent pandemic in the Celebes Islands. At the height of the tourist season, the Spanish Government confirmed several cases of cholera in the northeastern province of Zaragoza while thousands of Spaniards in that city waited in line to be inoculated against the disease. This disease remains unconquered and a symbol of a way of life where safe water is still an unattainable luxury.

American communities are concerned over waterborne viral disease. This concern exists despite the fact that of the enteric-viral diseases, only infectious hepatitis has been shown to be waterborne, but proving a waterborne character for infectious hepatitis has been difficult because of its prolonged incubation period and the inability to isolate and identify the causative virus.

The literature of the past suggested that poliomyelitis may be transmitted through sewage-contaminated water, especially in the course of swimming; and these theories have been revived from time to time with the demonstration of the poliomyelitis virus in sewage and other waste waters. While this possibility cannot be denied, it is extremely difficult to accept this as an important mode of spread. The theory would certainly not explain the general occurrence of the disease in the past, especially the large number and wide distribution of abortive cases, nor would it explain the wave-like character of spread. The spread of poliomyelitis in urban areas has not followed the water distribution system; on the contrary, with one possible exception,[3] there is no epidemic on record in which the pattern of spread was consistent with the hypothesis of transmission through sewage-polluted water.

The pollution of bathing beaches is a constant source of anxiety for community health specialists, and it is customary for these recreational areas to

be kept under constant surveillance. Nevertheless, convincing evidence to incriminate bathing in polluted water as a cause for outbreaks of intestinal disease is extremely hard to find. A few outbreaks of typhoid fever between 1920 and 1932 seemed ascribable to this mode of infection, but in extensive retrospective studies, only a few sporadic paratyphoid infections were attributable to bathing in natural bathing beaches.[4]

From a community health vantage, the importance of virologic concern with community water supply may not be related to major outbreaks but to low level transmission and the seeding of communities with viruses.

Unfortunately virologic technics have not developed to a point where virus enumeration can be recommended as a routine procedure in the examination of waters.

Only three epidemiologic studies[5] have been reported in this country which were designed to relate bacterial quality of natural bathing waters to human health. None of the three was conclusive or even highly suggestive as to suitable water quality standards for recreational waters. Eye, ear, nose, and throat ailments were the dominant illnesses reported. Gastrointestinal disturbances, the type that would be caused by fecal bacteria, accounted for 20 percent or less of the complaints. Swimmers showed distinctly higher rates of illness than nonswimmers, regardless of the bacterial quality of the water, a point which has been noted in other studies of illness experiences of swimmers.

A "new" disease has been reported as being acquired from swimming in fresh or brackish water. Amoebic meningoencephalitis, caused by a small free-living ameba, *Naegleria gruberi,* has epidemiologic features which suggest a waterborne origin. In fact, Butt[6] reported three fatal cases of primary amebic meningoencephalitis in which the evidence indicated that the disease was acquired during warm weather by swimming and diving in fresh water lakes or streams. Apley et al[7] reported a case of meningitis in a child that may have been acquired by playing in a mud puddle. Callicott[8] and Duma[9] in separate papers have reported similar cases.

Retrospective studies of this infection and studies of environmental factors that influence the biology of ameba are underway, and the results of these investigations should indicate the true scope of this disease and suggest methods of prevention and control. As Franklin Neva, M.D., asked in a recent editorial in the *New England Journal of Medicine:* "Is this another example of a new disease pattern that man has created by fouling his environment?"[10]

Unquestionably, recreational or occupational exposure to surface water increases the range of disease that can be acquired because of the accessibility of multiple portals of entry for microorganisms, but gastrointestinal infections seem to play a small role, if the data thus far in the literature can serve as a reliable basis for this conclusion. However, infections of nasopharynx, mucus membranes, and skin abrasions would appear to be fairly common among persons frequently exposed to natural recreational waters.

Chemical Pollutants

Any review of water hygiene and community health must consider the major "new" water pollution problem which has emerged with the growth of the synthetic chemical industry. Wastes from this industry are reaching water courses in increasing numbers and amounts each year, both from the use of the manufactured products and from wastes produced during their manufacture. These chemicals reach the stream by way of municipal and industrial sewers, land drainage, or direct application of chemicals to the stream, lake, or impoundment.

Waste and products originating with the synthetic chemical industry are extremely complex in their composition and behavior. Many do not respond to modern water treatment procedures and they may therefore persist in streams for long periods of time. We do not have readily available technics to detect most of these compounds in water, nor can they be removed from waste effluents. In fact, we know very little of the possible effects on community health at environmental levels. The urgency to evaluate these hazards is high on the list of community health priorities, but the difficulties are well-known and have been described in a comprehensive review by Stokinger and Woodward.[11]

Further light is focused on this problem by Dr. James Neel, Department of Human Genetics, University of Michigan.[12] He indicates that there seems to be very little danger of massive genetic damage from trace chemicals in water supplies, but it is highly possible that trace chemicals have increased human mutation rates. He further suggests that our ignorance of chemical mutagenesis in man or other mammals is such that it is impossible to find data to sustain even a brief argument.

Likewise, the role of carcinogenic substances and irritants is far from clear. The presence of such substances in a community water supply adds imponderably to the difficulty of setting a satisfactory water standard for such substances. Permitting no measurable quantity of carcinogenic agents in water would appear to be the only present means of dealing with such material, but it is scarcely a practical one.[11]

Russell has recently detailed the possible health effects of a sodium imbalance as an environ-

ental pollutant in drinking water.[13] Studying the Santa Ana River, which serves as a principal water supply for Orange County, California, he found that 39.7 percent of the residents within that water district were supplied with water containing 110 milligrams or more of sodium per liter.

The county morbidity data for 1968 revealed that 54 percent of the deaths were caused by nine disease groups associated with high sodium retention. Data presented in that report, although incomplete, suggest the need for a more comprehensive study on the engineering, medical, and community health aspects of the sodium content of domestic water supplies.

Nitrate in community water supplies had always been regarded as a harmless constituent until Comly[14] suspected the chemical as a cause of certain cases of methomoglobinemia in infants. Additional research by others corroborated Comly's hypothesis. Since 1945, more than 2,000 cases of infantile methomoglobinemia have been reported in North America and Europe. From 1947 to 1950, there were 139 cases due to nitrates in well waters reported in Minnesota alone; this included 14 deaths.[15] Waste from fertilizer plants and field fertilization are the usual sources of nitrates but they may also be dissolved from soils containing large amounts of animal refuse. Nearly all surface waters of safe quality contain nitrogen as nitrates in amounts varying from 0.1 to 1.0 part per million. However, there is considerable seasonal fluctuation due to the use of nitrates for food by algae and other forms of plant life.

From the toxicologic viewpoint, Winton and co-workers[16] undertook a study to determine whether the present public health specifications for nitrate content in tap water is too arbitrary. Results were not definitive, but there were indications that present recommended nitrate limits provide a valid margin of safety when the water is used for infant intake.

Variations in individual susceptibility to amounts of water consumed in proportion to body weight, and method of formula preparation are all variables which influence the development of methemoglobinemia. These variables also make the exact establishment of safe limits somewhat difficult. However, current Public Health Service recommended limits [45 P.P.M.] on nitrates are based on the premise that practically no control can be exercised over these variables.

Water mineralization and its influence on the course of coronary heart disease (CHD) and cardiovascular disease (CVD) has also been investigated by several workers during the past decade.

Morris, Crawford and Heady[17] described a highly negative correlation between water hardness and cardiovascular mortality in England and Wales. Lindeman and Assenzo[18] explored the cardiovascular disease and soft-water correlation in Oklahoma and reported a positive but statistically insignificant correlation. Mulcahy[19] was able to show no correlation in similar studies conducted in the Republic of Ireland. From the Netherlands, Biersteker[20] reported a statistically negative correlation between water hardness and CVD in women but not in men. With the current trend toward artificially softened water, the work of Robertson[21] is of interest. He found that mortality from CVD significantly increased in the English town of Scunthorpe several years after the town started softening its municipal water supply.

Schroeder,[22,23] a long-time student of this problem, suggested that cadmium is perhaps the real factor, and he reasons that corrosive soft water leaches cadmium from galvanized pipes and that this could readily enter a community's water supply. It has also been shown that cadmium in the kidneys can contribute to hypertension in some of the lower vertebrates and that a deficiency in chromium (trivalent state) favors arteriosclerotic disease. But here again is a large area in which the data are insufficient to clearly reject or accept the suggestions that there is a water quality factor influencing to any degree the development of certain cardiovascular disease.

As Abel Wolman[24] recently concluded: "Although the disease evidence is elusive, some have been unable to resist the temptation to alarm the public by less than convincing data."

Water Quality Standards

The origin of current drinking water standards can be traced back to some 51 years ago when Congress passed a law, which required the U.S. Surgeon General to establish interstate quarantine regulations. The first standards developed in 1914 included bacteriologic quality consistent with federal responsibility for communicable disease control. Since 1914, revisions [1925, 1942, and 1946] have covered inorganic chemicals, radioactivity, and in 1962, organic chemicals. It has been said that as testing procedures become more and more delicate, more ingredients will be added to the prohibited list; and several community health specialists have questioned whether this move toward zero risk is being considered realistically against resulting health benefits—or at what price.

According to Wolman,[24] the tacit assumption prevails with many, that water, having no external constituents, natural or man-made, is a universal desideratum. This concept, which needs serious scientific debate, is already becoming embedded in law, regulation, and voluntary association policy. He concludes: "One can undoubtedly produce any tailor-made water the consumer needs or desires.

The important questions in each instance remain as to when, where, and at what price?"

It should be acknowledged that the present water quality standards are basically performance specifications; instead of providing the means by which standards can be met, they merely delineate goals. Since these standards are applicable to interstate carriers and disease control between states, only about 600 places in the United States are subject to federal inspections and regulations. Actually the revision of drinking water standards is now being considered within the federal establishment and will probably be brought to fruition as the new U.S. Environmental Protection Agency begins to devote more manpower and financial resources to this aspect of the water environment.

The American Water Works Association has already indicated its intention to work toward standards whose requirements can be translated more directly into measurements of water quality and which will be more refined as to specific contaminants.

On the other hand, community health officials have worked for many years to maintain certain bacterial standards for recreational waters. These standards are based on the coliform group, the same microorganisms used to assess drinking water quality. Coliforms were originally believed to be entirely of fecal origin, but it has been shown that *Aerobacter* and other coliforms can grow in soil, on vegetation, and in other contacts of the physical environment. Thus, the presence of coliforms does not always mean fecal pollution. There are opinions among some sanitary microbiologists that bacteria of the nose and throat are better indices of pollution load than coliforms. But Edwin Geldreich,[25] world leading authority on water microbiology, suggests that fecal streptococci merit consideration in water quality criteria, since these organisms are now being employed in many stream measurements. Generally, the occurrence of fecal streptococci in water indicates fecal pollution and their absence indicates little or no warm-blooded animal contamination.

Henderson[26] has criticized the use of fecal coliform limits of 200 organisms per 100 ml as being unrealistic to the incidence of illness that is associated with the use of natural bathing water. There is, in fact, no significant epidemiologic basis for the total coliform standards used to assess the quality of bathing water. Commenting on the problem, E. R. Krumbiegel, M.D., Commissioner of Health for the City of Milwaukee, said "The Milwaukee Health Department has applied standards for bathing water quality which are more tolerant of coliform organism concentrations than any standard I know of. Are the Milwaukee standards too lenient or are they more restrictive than is necessary?" The same fundamental question can be raised about standards for recreational water in the Great Lake Basin and other areas.

The simple answer is: we do not know. There is no evidence that human disease has been caused among persons swimming in water with a coliform in excess of 200, 500, or 10,000 per 100 ml. However, it has been noted that there is a sharp increase in the frequency of *Salmonella* when fecal coliform densities were above 200 organisms per 100 ml. Incidentally Cleveland's Public Health Laboratory, after considerable effort, could not isolate *Salmonella* from Lake Erie water samples during the Easterly mechanical failures last June. In this connection, Geldreich[25] concludes that the inability to detect *Salmonella* in some instances of fecal pollution does not imply poor correlation of the fecal coliform test, but indicates the highly variable occurrence of *Salmonella* outbreaks.

At the present rate, large sums of money are likely to be spent in the next decade primarily to meet bacterial standards, because of the demand for cleaner water for recreation. But there is no assurance that the money will be spent wisely unless a sound basis is established for such standards.

The Receiving Stream

No paper, no argument, no discussion of water quality proceeds very far without considering the receiving stream, a vital link in the entire water environment cycle.

Streams, lakes, and similar bodies of water have long been used for disposal of domestic sewage and industrial waste. As long as the quantity of waste remains below the stream's assimilative capacity, the normal biologic flora and fauna will be predominantly aerobic and beneficial to the community. Once the load of waste exceeds the stream's assimilative capacity, the higher forms of biologic life are displaced by an excessive growth of bacteria, and anaerobic conditions develop which may create a nuisance for the community. These disagreeable conditions may include masses of floating solids, production of offensive gases such as hydrogen sulfide, and death to fish and other aquatic life.

The primary problem of a stream's assimilative capacity lies in the low solubility of oxygen in water. This basic phenomenon caused much of the concern about Lake Erie last summer, especially during the period when untreated domestic waste was being discharged into this body of water.

The central basin of Lake Erie is by far the largest of the three basins and the water temperatures in this area are uniform from top to bottom from late fall to early spring. From June to September the Lake's temperature stratifies with a thermocline 50 to 60 feet below the surface. This

thermocline is usually so sharp that 75 F water is essentially floating in 55 F water during stratification. The relatively thin bottom, cool-water layer (hypolimnion) may loose all of its dissolved oxygen while the upper warm water (epilimnion) remains at or above saturation. The loss of dissolved oxygen in the hypolimnion is progressive and the minimum is usually recorded late in the stratification period (August or September). The hypolimnion begins to thin when the lake starts to cool in August and disappears in late September or early October. Then an oxygen-deficient zone no longer exists.

In swiftly moving streams, the oxygen used to stabilize organic waste is replenished quite rapidly. The water surface at the air-liquid interface is being continuously replaced by the turbulence of the stream movement. But, because of the central basin's large cross-section, the flow-through current is immeasurably slow, and circulation is controlled by the wind. Summer and winter circulations are similar in the central basin except that in summer the thermocline is, in effect, an elastic bottom which shifts in depth and location with stress caused by the wind. The thermocline, although it has no net movement, slides around in the basin, and this results in a resuspension of bottom sediment. The phenomenon hastens oxygen depletion in the hypolimnion. The failure to replace the oxygen being used in this lower region of the lake allows anaerobic conditions to develop, thereby generating a community nuisance.

Summary

Expanding industrial, agricultural, and recreational activities have accentuated a built-in paradox where more and more water is needed but less and less becomes available at the required quality.

It is not only quality that has to be preserved and ameliorated but quantity. The fact that a certain level of quality can be assured in a technologically advanced era and the fact that proper quantities for the same community activities are reckoned with does not mean that the total water needs of an area have been satisfied. We must also be concerned about equality and this cannot be achieved until water in the proper quality and quantity is available to meet every segment of community need, industrial, domestic, and recreational.

While many of the waterborne disease perturbations have been laid to rest, physicians and other enlightened professional and lay groups have become increasingly concerned about viruses and the wide spectrum of chemicals now reaching the water contact cycle. At the present level of exposure, water pollutants do not seem to have a significant acute effect on community health with the exception of nitrates, which can cause methomoglobinemia and death in infants. Less well-defined, however, is the potential for chronic effects caused by long-term, low-level exposure.

Nevertheless, the call is loud and clear for a revision of drinking water standards whose requirement can be translated more directly into measurements of water quality which will be more refined as to specific contaminants.

Equally as loud is the plea for bacterial standards for bathing beaches, based on sound epidemiologic data. How soon these pleas will be heard and responded to is, today, a matter of conjecture.

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GUEST EDITORIAL

Drug Abuse — The Physician's Responsibility

ALCOHOL remains the most commonly used mind-altering drug taken for reasons other than medical. It is a factor in half of all highway fatalities occurring each year in the United States, implicated in half of all homicides, 25 percent of suicides, 22 percent of all male first admissions to hospitals,[1] and much else. Coddington and Jacobsen, in this issue of *The Journal,* clearly show that the drug of choice for mood modification in Ohio's adolescents is alcohol. Studies in other locales indicate a similar choice.[2,3] By comparison, use of other drugs is small indeed.

Our local, state, and national governments are embarking on a wide range of approaches to combating "drug abuse" (usually excluding alcohol abuse). Millions of dollars are currently being spent in these various avenues. In the City of Cincinnati in 1971, approximately $1.4 million was contributed locally or received through grants for specific drug treatment programs. (Much more money was expended.) The City of Cincinnati expended only $145,550 for specific alcoholism programs. The recently passed state budget includes $7.2 million for drug abuse and only $1.1 million for alcoholism. It appears that our priorities are somewhat misdirected.

It has been seen in some studies[4,5] that there may be an inverse relationship between the amount of one drug a society or culture uses and the amount of another. Primarily, as indicated in the paper in this issue of *The Journal,* most people tend to rely on only one drug. The current "illicit" drug consumption by our nation's youth appears to be, in reality, only a change in the types of drugs used rather than an increase in nonmedical drug use. After all, the number of people in our society who use no drugs for mood modification, prescribed or otherwise, approaches zero.

Some would argue that the reason for the skewed expenditure in drug abuse versus alcoholism is that more serious dangers are inherent in the newer mood modifiers. This is a misconception. Physicians are well aware that alcohol is among the most physically destructive drugs known to man. Morphine, although having a low toxic-therapeutic ratio, is much safer than alcohol in many respects.

Currently, we have a situation likened, by many, to the alcohol prohibition of the 1920's. The law has treated our young drug user so harshly that, as some have said, the cure has become worse than the disease. This harshness is more the result of the cultural generation gap than based on any rationale. Physicians have abdicated their responsibility in this area. In drug abuse affairs, they are often the only people, other than law enforcers, to whom the public and legislators will listen. Other than recent support by the Ohio State Medical Association, few physicians in Ohio have become knowledgeable and active in this public health field. Adolescents have had problems ever since there have been adolescents. Jailing them for an obvious health problem will not provide the solutions.

Coddington and Jacobsen say that 20 percent of adolescents use "drugs" and that "we have a major health problem requiring the attention of Ohio's physicians." Almost all people (not only adolescents) use, and misuse, drugs. We, indeed have a major health problem. Physician awareness, support of local community programs, and input into setting the priorities and suggesting adequate legislation are greatly needed.

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The Medical School and the State Hospital

A Collaborative Effort in Education and Patient Care

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ISOLATION FROM ONE ANOTHER has often characterized the relationship between the state mental hospital and the department of psychiatry in the medical school. The Ohio State Medical Association has been interested in encouraging more effective relations between the Department of Mental Hygiene and the medical schools. During the past year the Department of Psychiatry of Case Western Reserve University School of Medicine and the Cleveland Psychiatric Institute have cooperated in developing a program of psychiatric education for third-year medical students. This paper is a preliminary analysis of that experience. We hope to point out the mutually beneficial aspects of such a program as well as to describe some of the problems involved in such an effort. In addition, we will describe the functioning of the program and some of the data that have been gathered.

Background

A change in the curriculum at Case Western Reserve School of Medicine occurred beginning in the academic year 1970-1971. The whole of the third-year curriculum is now composed of two-month rotations in the basic clinical specialties and the fourth year is primarily a year of electives. Psychiatry had previously been a one-month required clerkship in the fourth year. With the revision it became a required two-month clerkship in the third year.

Because of the curricular change, there was an increased pressure on psychiatric teaching facilities and faculty. In addition, the size of each medical school class began to increase. The existing university in-patient facilities, which had previously been able to handle a one-month rotation for a smaller class, were no longer sufficient to handle this increased load. In addition, the two-month rotation was enough time to offer the student a more intensive experience with patients. Our feeling has been that the student is capable of doing far more than he has traditionally been allowed. In the past, the third- or fourth-year medical stu-

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dent was in competition for patient time with interns and residents already assigned to a limited number of patients. Not only did we feel that the student was capable of more responsibility but that it was advisable to give responsibility to the student early in his career. This seemed particularly important in psychiatry, since the internship is no longer required for psychiatric residency training.

Within the medical school department of psychiatry, there are four psychiatric services operating in four different hospitals. One of the services, the department of psychiatry at Cleveland Metropolitan General Hospital (CMGH), was located adjoining a state hospital, Cleveland Psychiatric Institute (CPI). At the time of the curricular change, the newly established department at CMGH was about two years old and had developed with a primary focus on consultative services within the hospital. The consultation and brief treatment services offered were limited to in-patients and out-patients registered as patients of the hospital. There was no in-patient service at CMGH itself. With this operational arrangement and the close proximity of CPI, an excellent opportunity existed for cooperative effort in the development of a unique medical student experience.

Description of the Program

The overall goal of the educational program during each two-month rotation is to offer a comprehensive experience in clinical psychiatry for all students regardless of their career plans. The program is basically divided into two phases. The first phase is an in-patient experience which operates on a psychiatric unit at CPI. The second is evaluation of medical-surgical in-patients and out-patients for whom psychiatric consultation has been requested at CMGH. The emphasis in both phases of the program is to give the student as much responsibility in the evaluation and care of the patient as seems possible. In all contacts with patients, the student is encouraged to function independently, but with close faculty supervision. Each student is assigned a faculty member who supervises the evaluation as well as the treatment decisions and all orders are countersigned by the supervisor before being carried out.

The in-patient service at CPI consists of an 18-bed, all-female, locked psychiatric ward. At any one time there are six medical students involved in the program. The ward operation is directed by a member of the faculty (S.M.), who also closely supervises three students. Three additional faculty supervisors take part in the program. Patients are admitted to this ward on a rotating basis with the other services at CPI. There is no preselection of patients admitted to the ward, so that the students see a cross section of the routine admissions to a state hospital. The psychiatric evaluation and work-up of the patient is the responsibility of the student assigned to the case. There are no interns or residents on this particular ward, although there are residents on other wards in the hospital. The patient relates to the student as she would to any physician to whom she would have been assigned on another ward.

In addition to the medical staffing just described, there are others involved on the ward team. A social worker from the department of social service at CPI is permanently assigned to this ward. The social worker works with each student just as she would work with a resident or staff physician. A psychologist is assigned to the ward working with those patients that are in need of psychologic service. A recreational-occupational therapist is also assigned to the ward. The individual representatives of the disciplines mentioned are involved in ward meetings along with the student doctors and nurses to encourage the development of a smoothly functioning team. Their permanent assignment to the ward maintains continuity since the student doctors rotate every two months. The final and important component in the staffing of the ward is the nursing service. The pattern of staffing consists of one full-time head nurse who works during the day shift. Her daytime staff consists of between two and three psychiatric aids. The afternoon and evening shift is composed of either licensed practical nurses or trained psychiatric aids, numbering two per shift. Registered nursing supervision is supplied by a nursing supervisor who is in charge of a number of the wards in the hospital. In addition to the full-time nursing staff there is a nursing student program. There are about six student nurses present at most times along with their supervisor, a member of the CPI staff. The patients assigned to a given medical student are also assigned to a given nursing student. This allows both students to begin to experience the team approach in the care of the patient and allows communication and coordination in the care of any given patient.

Since the student doctors are on the service for only two months, after-care for the discharged patient cannot be supplied by the individual who cared for them in the hospital. This after-care is supplied, therefore, in the hospital out-patient department by the residents and staff of CPI. When the patient is prepared for discharge from the hospital, she is also prepared for transfer to the new doctor. In addition to this after-care follow-up, other facilities of the hospital are available to the patients on this ward as they are to the patients on any ward in the hospital. This includes access to out-patient social service, out-

atient psychologic services, and out-patient recreational therapy community services as well.

Results

The medical student service has now been operating for a total of nine months. The results to be presented are based on the first eight months of operation.

Perhaps the most significant data in the program are the reaction of the students and staff involved. These types of data are by nature impressionistic but none the less important in attempting to determine the value of such a program.

A total of 22 students participated in the program during the eight-month period. The initial feeling of almost all of them was anxiety and doubt as to their ability to assume the type of responsibility required of them. After being on service, however, almost all of them were convinced that they could and were doing the job and that the patients were being well cared for. The remark of one student who said, "When I first started I was convinced that the whole thing would never work, but after spending a month on the ward I'm convinced it's the only way to learn psychiatry," typifys the feelings of most students. During interviews at the end of the clerkship, most students said that they had experienced a great deal of professional growth as a result of their experience. Almost all of the students became acutely aware of the problems facing the state hospital. They developed a better appreciation of the problems facing the staff of the state hospital, since they had lived under the same personnel shortages and had experienced the same frustrations.

The general feeling of the ward staff had initially been one of doubt, anxiety, and concern regarding patient care. Within a matter of weeks after beginning the program, those concerns had disappeared and were replaced by surprise and delight over the students' abilities to care for the patients. The students made themselves very available and spent a great deal of time both with the patients and with the families of the patients. This coupled with close supervision by faculty members assured the ward staff of good patient care.

The faculty members involved were generally pleased with the program. They were surprised at the ability of the students to assume the type of responsibility given them. A great deal of staff time was required to operate the program. Each student was seen a minimum of three hours a week in supervision either alone or in groups. The quality of patient care and the growth of the student, however, made this time expenditure worthwhile.

During this eight-month period there were 97 admissions to the ward. This represented 92 patients so that in the eight-month period there were five patients admitted twice. A sample of 69 of the 97 discharge summaries was reviewed. This represented 65 patients. The average length of stay for this group was 33 days. The average length of stay in the hospital as a whole for the year July 1, 1969 to June 30, 1970 was 40 days. At the time of discharge, 48 of the patients admitted were rated both by student and supervisor as improved, and 21 were rated unimproved. Sixty-five admissions were discharged back into the community. Of these, five were discharged against medical advice. Four patients (5.9 percent) were transferred to long-term-care facilities. The percent of such transfers for the whole hospital was 11 percent.

A broad diagnostic spectrum was seen on the ward—the two most common discharge diagnoses were depressive neurosis (18), and one or another variety of schizophrenia (21). Of the 65 patients represented in this sample, 14 received multiple psychiatric diagnoses, the secondary diagnosis most often being a characterologic one (Table 1).

Discussion

The general impression of all involved in this program, both students and faculty, was that the effort was worthwhile although a great deal of faculty time was required to have such a program function smoothly. The students almost unanimously felt that they had not only gained insight into psychiatric problems but had grown considerably as physicians. All of the students felt more comfortable in making decisions and were effective in carrying out those decisions. The patients received a great deal of attention and understanding from the students and benefited by this availability of personnel. The hospital itself seemed quite able to incorporate a rather unusual program into its daily operation. There was a close relationship

Table 1. Diagnoses of 65 Patients Discharged.

Diagnosis	No.*
1. Hysterical personality	6
2. Anxiety neurosis	6
3. Depressive neurosis	18
4. Passive-aggressive personality	6
5. Inadequate personality	6
6. Mental retardation	2
7. Paranoid personality	1
8. Alcoholism	8
9. Schizophrenia	21
10. Antisocial personality	1
11. Other personality disorder	1
12. Nonpsychotic organic brain syndrome	2
13. Adjustment reaction of adult life	2
14. Homosexuality	1
15. Manic depressive-depressed type	1
16. Involutional paranoid state	1

*14 Patients received more than one diagnosis.

between the students and social service, recreational therapy, nursing, and psychology which resulted in better continuity of patient care. The students were able to gain a wide variety of experience from the general state hospital admission population. From the standpoint of the teaching service, the state hospital certainly seemed to provide adequate patient population for comprehensive experience either by the students or the resident staff.

The state hospital setting, despite all of the positive features, did have certain inherent problems which made the operation of a teaching service somewhat difficult. The most prominent problem was the nursing pattern on the ward. Psychiatric nursing particularly, we feel, has a great deal to teach students as well as having a very important place in patient care and management. The service described in this paper had one registered nurse permanently assigned to the ward. This nurse functioned during the day shift, and following that, the ward was without a full-time registered nurse immediately on duty. In order to maximize the teaching potential of such a situation, more professional nursing personnel should be available so that a student could observe and participate in a more satisfactory nursing approach to patient care. In addition, various treatment procedures which would have been desirable both from the standpoint of teaching and improved patient care, were not possible due to the nursing shortage. Similarly, the lack of a laboratory facility immediately available makes it difficult to handle certain problem patients who have concurrent medical and psychiatric illnesses. The limited nursing staff coupled with limited laboratory services necessitated the transfer to the general hospital of patients who could have been, perhaps should have been, treated more appropriately on a psychiatric ward using medical consultation when needed. Although it is our goal to emphasize the interrelationships between medical and psychiatric problems, the lack of back-up facilities makes it difficult to treat patients who could exemplify this type of interrelationship.

Summary

Although problems do exist in running a teaching service for medical students in a state hospital setting, the overall impression of the program is quite positive. It seems clear that a state hospital offers a great deal of potential for the development of teaching programs. Although the program described has had and continues to have problems, the overall effect has been positive and the relationship between the medical school and the hospital has been beneficial to both.

Discussion of E.N.T. Case of the Month

(continued from p. 480)

A child with the possible ingestion of a caustic substance, particularly an alkali, should be admitted to the hospital for further evaluation. The *absence of burns in the mouth does not rule out the possibility of an esophageal burn.*

Gastric lavage or the induction of vomiting are *contraindicated* because they may either rupture a weakened esophagus, or more likely reintroduce the caustic material from the relatively resistant stomach back into the fragile esophagus.

When a burn is present, corticosteroids have been shown to be useful in the prevention of esophageal stenosis. However, they must be started within 48 hours following the burn to be effective, making early diagnosis imperative.

Since radiographic studies are of little value in diagnosing an early burn, the diagnosis must be made by direct esophagoscopy, preferably within the first 24 hours. There is little danger of esophageal perforation with this procedure, even when a severe burn exists, because the esophogoscope is not introduced *past* the burn.

When a burned area is found, corticosteroid-antibiotic therapy should be started immediately.

Professional Activities



ON THE OMPAC FRONT

Tax Credits and Tax Deductions for Political Campaign Contributions

Regulations issued by the Internal Revenue Service on the new U.S. law relating to contributions to political campaigns include the following which will be of interest to physicians (and others) who make financial contributions to further the candidacy of any person running for Federal office.

Contributions made after December 31, 1971 directly to candidates or to candidate support committees **are eligible for favorable income tax treatment.**

Contributions made after December 31, 1971, to local, state (OMPAC) and national (AMPAC) political action committees **are not eligible for favorable income tax treatment.**

Contributions for political dinners **are eligible** for the favorable income tax treatment.

"**Favorable income tax treatment**" may take the form of tax credits or tax deductions. An individual taxpayer filing a joint return who donates to a candidate or candidate support committee is allowed to take a tax credit (reduce his tax liability) equal to one-half of his total contributions up to a maximum of $25.00 ($12.50 on a separate return). As an alternative, an individual taxpayer filing a joint return who donates to the candidate or a candidate support committee is allowed to take a tax deduction (reduces taxable income) for his total contributions up to a maximum of $100.00 ($50.00 on a separate return).

Why aren't contributions to local, state and national political action committees (OMPAC and AMPAC) eligible for the favorable income tax treatment?

The Internal Revenue Service has made the following interpretation on this:

The statute requires that eligible contributions are those given to a committee "organized and operated **exclusively** for the purpose of influencing the nomination or election" of an announced candidate. Contributions will not qualify for deduction or credit if made to "political action committees" which engage in general political, educational, or legislative activities. A campaign committee may be run in conjunction with such a political action committee (ie. the candidate support committee), but contributions to the campaign committee will be eligible only if received directly from individual taxpayers and not from the political action committee. Contributions made by individual taxpayers to a political action committee will not be eligible even if such contributions are later contributed by the political action committee to a campaign committee.

A unique service for help in the treatment of severe acne is being offered by the Acne Clinic of the Department of Dermatology, University of Cincinnati Medical Center. The service opened early in April and is available for interested persons in the Greater Cincinnati area. The clinic is held the first Wednesday afternoon of each month in Pavilion A of Cincinnati General Hospital.





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brand of (metronidazole)



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. The oral form is indicated also for intestinal amebiasis and amebic liver abscess.

Contraindications: Evidence or history of blood dyscrasia, active organic disease of the CNS, the first trimester of pregnancy and a history of hypersensitivity to metronidazole.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in EKG tracings.

Dosage and Administration

For Trichomoniasis. In the Female: One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during, and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male:* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

For Amebiasis. Adults: For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days.

Children: 35 to 50 mg./kg. of body weight/24 hours, divided into three doses, orally for ten days.

Dosage forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

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OSU Sponsors Fourth Annual Urologic Outing

The Fourth Annual Ohio State Urologic Outing will be held at Avalon Inn at Warren, Ohio, on July 31, and August 1-2, 1972. The subject is "Urologic Infections," and arrangements have been made for an outstanding guest and Ohio State University faculty to present the subject which is of keen interest to all urologists and allied medical fields.

The guest faculty includes Dr. Arthur Evans, professor and head of urology at the University of Cincinnati, Dr. Clair Cox, professor of urology at Bowman-Gray School of Medicine in Winston-Salem, North Carolina and from Ohio State, the Pomerene Professor of Infectious Diseases, Dr. Samuel Saslaw.

The format remains the same as for previous outings, in that the informal meetings will take place from 9:00 a.m. to 12:30 p.m. on each of the three days, leaving the afternoons and evenings free for relaxation and recreational activities desired by the attendees and families. As before, the registration fee is $60.00. For registration material, write Chester C. Winter, M.D., Room N-809, University Hospital, Columbus, Ohio 43210.

Ohio Medical Golfers to Meet on Marion Greens

The annual tournament of the Ohio State Medical Golfers Association will be held at the Marion Country Club, Marion, on Tuesday, June 20.

This is an 18-hole event and cups will be going to the player with the low gross and low net, as well as to the low gross and low net in the different age categories. There will be door prizes. Luncheon and dinner will be served at the club.

All Ohio physicians are invited to participate in this tournament, regardless of whether or not they have participated in the past.

For additional details, contact the tournament chairman, C. J. Shamess, M.D., 74 Wood Street, Mansfield 44903.

Dr. William A. Reed was presented the Burton Jaycees Distinguished Service Award at recent ceremonies in Burton. He was cited for participation in numerous community projects as well as for promotion of increased and improved hospital facilities in the area.



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President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

Obituaries

Anna May Young Beard, M.D., Cleveland; Western Reserve University School of Medicine, 1926; aged 74; died February 13; former member of the OSMA; diplomate, American Board of Pathology; practitioner of long standing in Cleveland, specializing in pathology. She was the widow of Dr. Edmund E. Beard, who died in 1962.

Louis H. Brooks, M.D., Cleveland; Ohio State University College of Medicine, 1931; aged 63; died March 24; member of OSMA and former member of AMA; member of American Proctologic Society; practitioner for many years in the Cleveland area and associated with Suburban Community Hospital; veteran of World War II.

Alexander Taylor Bunts, M.D., Cleveland; Harvard Medical School, 1924; aged 74; died February 13; member of OSMA, AMA, American Association of Neurological Surgeons, and Central Neuropsychiatric Association; Fellow, American College of Surgeons; diplomate, American Board of Neurological Surgery; associated also with a number of other professional organizations; neurosurgeon of long standing in Cleveland and associated for many years with the Cleveland Clinic; coauthor of the History of the Cleveland Clinic. His father, the late Dr. Frank E. Bunts, was one of the founders of the Cleveland Clinic.

Herbert Charles Duber, M.D., Cleveland; Ohio State University College of Medicine, 1948; aged 50; died March 17; member of OSMA and AMA; diplomate, American Board of Internal Medicine; practicing physician in Cleveland, and member of the faculty at Case Western Reserve University School of Medicine; veteran of World War II.

John P. Greenlees, M.D., Glouster; Ohio State University College of Medicine, 1945; aged 49; died February 27; member of OSMA and former member of AMA; practicing physician in the Athens County community for more than 20 years; served in the Army Medical Corps, 1946-1948.

John Francis Heggie, M.D., Columbus; Columbia University College of Physicians and Surgeons, 1955; aged 42; died March 21; resident physician at the Columbus State Hospital.

Peter William Hess, III, Cincinnati; University of Arkansas School of Medicine, 1931; aged 67; died February 29; member of OSMA, AMA, American Geriatrics Society, and American Academy of Family Physicians; practitioner of long standing in Cincinnati; veteran of World War II.

George James, M.D., New York; Yale University School of Medicine, 1941; aged 56; died March 19; former member of OSMA; former Akron health commissioner; since 1965, dean of Mount Sinai School of Medicine in New York City.

Fred Alexander Lutz, M.D., Mt. Sterling; Ohio State University College of Medicine, 1916; aged 80; died March 12; member of OSMA and AMA; practitioner of long standing in the Mt. Sterling area; veteran of World War I. Dr. W. Beale Lutz, of Columbus, is a son.

Walter Rae Mills, M.D., East Springfield; Ohio State University College of Medicine, 1914; aged 83; died March 4; member of OSMA and AMA; general practitioner for some 56 years in the East Springfield area.

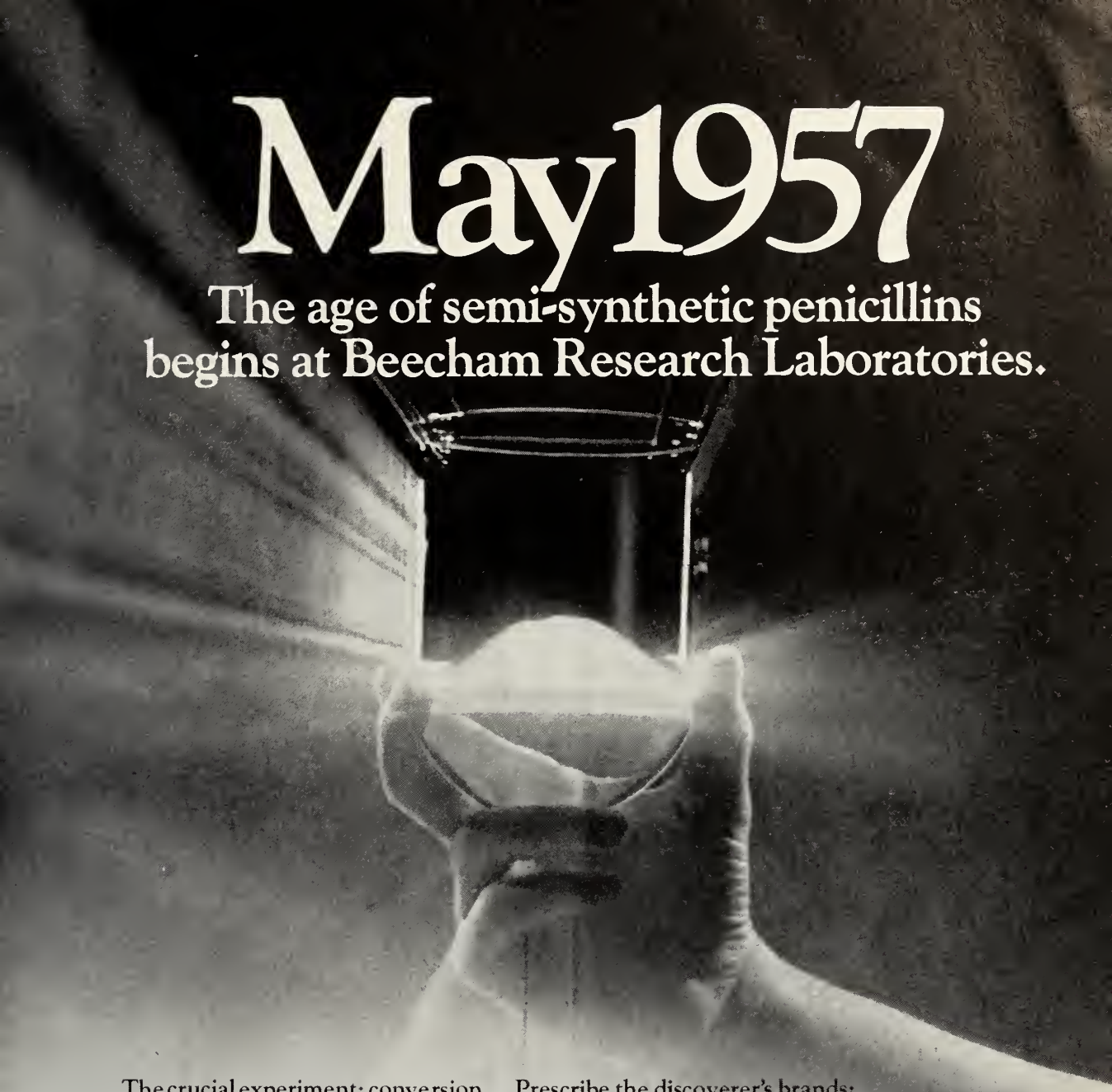
Theodore Minges, M.D., Cincinnati; University of Cincinnati College of Medicine, 1912; aged 83; died March 16; member of OSMA, AMA, Industrial Medical Association, and American Society of Abdominal Surgeons; practitioner of long standing in Cincinnati, specializing in surgery and industrial surgery. Dr. Ralph Minges is his son.

Thomas Edwin Rardin, Sr., M.D., Columbus; Ohio State University College of Medicine, 1930; aged 65; died March 14; member of OSMA, AMA, and American College of Family Physicians; general practitioner of some 40 years standing in Columbus; leader in the family practice field and helped to found the Ohio Academy of Family Physicians, the Section on General Practice of the AMA, and the American Board of Family Practice; recipient of the OSMA Distinguished Service Award in 1969 and the American Board of Family Practice's Founders Award in 1971; member of the Faculty at the OSU College of Medicine; veteran of World War II. His son, Dr. Thomas E. Rardin, Jr., is a practitioner in Ashville, N.C.

Robert Morgan Stecher, M.D., Lakewood; Harvard Medical School, 1923; aged 76; died March 13; member of OSMA, AMA, American Rheumatism Association, Central Society for

May 1957

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Clinical Research, International Academy of Pathology, and American Academy of Physical Medicine and Rehabilitation; Fellow, American College of Physicians; also associated with a number of other professional organizations; practitioner for 40 years in Cleveland, specializing in arthritis; member of the faculty at Case Western Reserve University School of Medicine.

John Robert Scherer, M.D., Portsmouth; Ohio State University College of Medicine, 1935; aged 60; died January 12; member of OSMA and AMA; practitioner for many years in Portsmouth, specializing in general surgery.

Harry Strauss, M.D., Cleveland; University of Toronto Faculty of Medicine, 1932; aged 64; died March 25; member of OSMA and former member of AMA; diplomate, American Board of Internal Medicine; practitioner in Cleveland for virtually all of his professional career.

William Henry Turner, M.D., Oberlin; University of Virginia Medical School, 1918; aged 81; died March 5; member of OSMA and AMA; former medical missionary in China; physician for the Oberlin College Health Service from 1944 to 1956 and from 1958 to 1960; retired in recent years.

Homer Virgil Weaver, M.D., Canton; Western Reserve University School of Medicine, 1923; aged 75; died March 20; member of OSMA, AMA and the American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Otolaryngology; practitioner for 38 years in Canton, specializing in the EENT field. Dr. James F. Weaver, also of Canton, is a son.

J. Keith Welborn, M.D., Toledo; Ohio State University College of Medicine, 1957; aged 39; died March 2; member of OSMA and AMA; Fellow, American College of Surgeons; diplomate, American Board of Surgery; practicing surgeon in the Toledo area since 1966; assistant clinical professor of medicine at the Medical College of Ohio at Toledo.

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Methyltestosterone N.F.-5 mg.

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Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17 -Hydroxy-17-Methylandrost-4 en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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Empirin Compound with Codeine No. 3 contains codeine phosphate* (32.4 mg.) gr. ½. No. 4 contains codeine phosphate* (64.8 mg.) gr. 1. *(Warning—may be habit-forming.) Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.



When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

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Skin and mucous membranes—Skin rash urticaria, vaginitis, and rare instances of e foliative and vesiculobullous dermatitis ha been reported. *Liver*—Although no direct lationship to liver dysfunction is establish jaundice and abnormal liver function te (particularly serum transaminase) have be observed in a few instances. *Cardiovascu*—Instances of hypotension following par teral administration have been report particularly after too rapid IV administ tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adm istered IV, dilute in 500 ml of fluid a administer no faster than 100 ml per ho *Special senses*—Tinnitus and vertigo h been reported occasionally. *Local reacti*—Excellent local tolerance demonstrated intramuscularly administered Linco (lincomycin hydrochloride). Reports of p following injection have been infrequ Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in disti water or normal saline has produced local irritation or phlebitis.

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Ohio Radiological Society Schedules Cincinnati Meeting, May 12-14

The Ohio Radiological Society has scheduled a Scientific Program in Cincinnati, Friday, Saturday, and Sunday, May 12, 13, and 14 (immediately after the Annual Meeting of the Ohio State Medical Association).

First event is a Buffet luncheon at the Crest Hills Country Club, followed by golf and other outdoor activities. Cocktails and dinner are scheduled on the Johnston Party Boat with a cruise on the Ohio.

On Saturday, May 13, registration opens at 8:30 a.m. at Stouffer's Inn, downtown Cincinnati.

Guest lecturer is C. John Hodson, CRCP, FRCP, FFR, professor and chairman, Department of Radiology, Memorial University of Newfoundland, Canada.

Saturday Program

Destructive Lesions of the Renal Parenchyma—
Dr. Anthony F. Lalli

What Happens, and Can Happen, in Ureteric Obstruction—
Dr. Hodson

Diagnostic and Prognostic Connotations of Radiographic Studies in Hypertension—
Dr. Thomas F. Meaney

Drugs, Bugs and the Kidney—
Dr. Hodson

The Arteriographer Looks at the Kidney—
Dr. Charles H. Kuntz

The Role of Radioisotopes in the Evaluation of Renal Disease—
Dr. Donald Gunderson

Sunday Program

Brunch and business meeting beginning at 8:30 a.m.

The Radiologist Looks at Renal Anatomy—
Dr. Hodson

Therapy Workshop—Wilms' Tumor—

Diagnostic Radiological Evaluation
Dr. William McSweeney

Surgery—
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Chemotherapy—
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Diagnostic Film Reading Session—
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For additional information, contact, Dr. Harry Horwitz or Dr. Harold Schneider, cochairmen, Department of Radiology, Cincinnati General Hospital, Burnet Avenue, Cincinnati 45229.

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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

"The golden moments, quick to haste
Some noble work of love to do . . . . ."

THAT QUOTATION from the works of Daniel Clement Colesworthy comes to mind as I finish reading the news releases from National headquarters on the fast-approaching 50th anniversary of the Woman's Auxiliary to the American Medical Association. Not being much of a mathematician, I can't break down into specific figures the thousands upon thousands upon thousands of "golden moments" that add up to the 50 years of Auxiliary in its "noble work of love" for the medical profession.

If I begin to sound corny at this point, be assured of this: there's nothing wrong with a sentiment that can point with pride to half a century of outstanding activity, accomplishment and dedication on the part of America's doctors' wives.

This 1972 convention will be witnessing the memorable occasion in a glamorous, intriguing city—San Francisco. The dates for the gala celebration are June 18 through June 22. Headquarters will be the lovely St. Francis Hotel. Registration will begin on Sunday morning at 9 a.m. on the Mezzanine.

Highlighting the activities will be a "Salute to the Auxiliary" at the opening session of the AMA House of Delegates on Sunday, June 18 at 2:00 p.m. in the Hilton Hotel—a first for the auxiliary. There will be a multimedia, slide-sound and film presentation depicting the auxiliary's accomplishments, featuring both live talent and taped sequences in which professional actresses and actors take part. It all sounds like a terrific and effective visual telling of "Our Story."

Sunday will also highlight another special occasion—the Reception and Party honoring Mrs. G. Prentiss Lee, National President, and Mrs. Robert F. Beckley, President-Elect. The festivities to which members, husbands and guests are invited will be at the St. Francis from 5 to 7 p.m.

"The Agenda"

The auxiliary convention will begin Monday morning, June 19 at the St. Francis, with the call to order by Mrs. Lee. (At 7:30 a.m. that same morning, the Ohio delegation will hold its traditional breakfast. This is always a very special event—a warm and enthusiastic "gathering of the clan" . . . .) Also scheduled for Monday morning is the election of the 1972-73 officers.

Guest speaker at the Monday luncheon will be Art Linkletter who will discuss "Changing Patterns in Drug Abuse." Tuesday morning will feature the "Idea Exchange," a state presidents' program presentation. The morning's keynote speaker will be Edward J. Stainbrook, M.D., professor and chairman of the Department of Human Behavior, USC School of Medicine. Tuesday's luncheon should prove dear to every woman's heart—a fashion show is scheduled that will turn the spotlight on Oriental Fashions.

At Wednesday morning's session, there will be awards and special reports. The high point will be the installation of the 1972-73 officers and

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the inaugural address of Mrs. Robert F. Beckley. Following the adjournment of the convention on Wednesday, members and guests are invited to a Napa Valley Wine Tour and Luncheon in the garden of the Charles Krug Winery. Cost of the tour is $12 and includes luncheon, wine tasting, transportation and gratuities. Tickets will be available at auxiliary headquarters in the St. Francis. Buses will leave the hotel at 10:30 a.m. and 12:00 noon and will return at 4:30 p.m. and 5:30 p.m.

What I have recorded here on the 50th anniversary convention to be held in June is, of course, merely a bird's-eye view. There will be much more to interest and excite and surprise those lucky enough to be in San Francisco. At this moment, the melodic strains of "California, Here I Come" is infiltrating deep into my consciousness and will continue to haunt me relentlessly. And I bet I'm not the only one who will be so tantalizingly affected!

Teen-Agers Only

As in past years, a complete program of youth activities is being planned by the convention's teen-age committee. There will be three special tours and here's a rundown on each:

On Monday, June 19, from 1:00 p.m. to 6:15 p.m.: a Boat Cruise of San Francisco Bay and a tour of the old Sailing Ship Balclutha and the wax museum. Buses will load on the Post Street side of the St. Francis Hotel for a ride to Fisherman's Wharf where young people will board one of the spacious Princess Line cruise ships for a tour of the Bay. Then on to the Balclutha, a square rigger English ship built in 1886 and used for merchant trade. A short walk brings participants to the wax museum, brought directly from London, England where 200 life-size wax figures can be viewed in a setting of 60 scenes. Cost of the Monday tour: $7 per person.

On Tuesday, June 20, from 9 a.m. to 4 p.m.: The Frontier Village Amusement Park. Exciting rides, gold panning, trout fishing, a penny arcade and an authentic Indian Island are all part of the Frontier Village in San Jose. The young people will relive the days of the old Wild West with such sights as gunfights and bank robberies on Main Street (all in fun, but of course!). They will see a Wild West Stunt Show and authentic Indian dancing. Participants should bring lunch money with them, but the *$7 price of admission* includes unlimited rides and attendance at all events.

On Wednesday, June 21, from 9 a.m. to 4 p.m.: Marine World on San Francisco Bay. This is a fascinating spot, 60 acres of family fun right on the Bay near Redwood City. Sixteen exciting attractions are located here, including the world's largest performing killer-whale and trained baby whales, a water skiing and speed boat show, the world's only water skiing elephant and a porpoise petting pool. Admission is $8 per person including lunch.

Plenty of excitement and fun, wouldn't you say, for the young 'uns?? Registration for the above tours will begin Sunday, June 18 at 11 a.m. in the Borgia Room of the St. Francis. However, the chairmen of the Teenage Committee urge that advance registration be made if at all possible. Such registration can be sent in to the Woman's Auxiliary, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

AMPAC Workshop

I have before me a very interesting and informative letter from Mrs. Malachi W. Sloan, II, past state president, legislation chairman and member of the OMPAC Board. It's all about the recent AMPAC Workshop in Washington, D.C. at the Washington-Hilton and I'm going to let Jane Sloan tell it to you in her own words, because she tells it so well:

"After four years of getting to this annual meeting, there were many familiar faces in the crowd. This year, the women on PAC Boards, as well as our National Auxiliary brass, were invited to a "coffee" in the lovely VIP suite. It was fun to meet informally and begin to get the flavor of the Workshop. Our hostess, Mrs. Hoyt Gardner, is the wife of the personable chairman of AMPAC. It was evident that this group of gals was both enthusiastic and professional in the realm of politics.

"The treat of the first day was the gala reception at the Kennedy Center for the Performing Arts. Every woman donned her prettiest dress —mostly floor length for the occasion. It was worth it—from the moment we entered the beautiful and inspiring Grand Foyer where the display of flags is a thrilling sight. A golden sunset added to the beauty since it seemed to make everything more mellow. The reception room was lovely—much red carpet and red velvet. We really enjoyed the ample buffet and libation and the renewal of old friendships. The climax of our evening came in the Concert Hall where we heard the remarkable Van Cliburn in concert. Wish I could tell you adequately the sensation that ran through the vast audience as he came on stage and quietly and majestically played our National Anthem. This evening was one to remember with joy for many a day.

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dress of Dr. Max Parrott, chairman of the AMA Board of Trustees. To jump from that (for the moment!)– the concluding speech at 1:30 p.m. on Sunday was given by Rep. Joel T. Broyhill who introduced our Medicredit Bill in the 92nd Congress. Needless to say, this span of hours from Dr. Parrott to Representative Broyhill was broken down into time slots for panel discussions, films, TV program—and fun.

"The theme running throughout the Workshop pointed up 1972 as the crucial year for medicine and was geared to get PAC members active in the upcoming national election. Our job is to support incumbents who have been friendly toward medicine. Our job is further to work to elect new friends of medicine running for office. In short, our job is to make our influence felt wherever we can.

"Presently there are 163 sponsors of the Medicredit bill but this does not insure passage. Many bills are being given consideration. The AMA—all of us—must fight for the chance to help write the bill which will finally become law. We must fight to preserve the patient-doctor relationship as well as the preservation of quality health care. As wives of physicians, we would be in error not to be part of the body politic and in error to divorce ourselves from the opinion makers, according to Dr. Parrott.

"Ohio played a role in this National Workshop. Dr. W. J. Lewis, a member of the Board of both OMPAC and AMPAC, gave the final challenge to the general assembly in his '72 Game Plan speech. He is a fine speaker and we were proud of him. I had a delightful duty to perform since I served as one of 12 hostesses at the Sunday morning breakfast. There were about 50 guests in the room in which I served. It was my job to welcome them and introduce the 'TV-Coffee', a new concept in candidate support work. Everyone enjoyed this experience and hopefully we can put it to work somewhere in Ohio.

"These were very busy and exciting days for the 800 or more in attendance. Enthusiasm for the great cause of quality health care was unmistakable. One could hear the political drum beats of a most important election beginning to sound. I came away eager to get to work in Ohio!"

Thank you, Jane Sloan, for a most articulate presentation of the mood, the purpose, the hopes, the goals of that AMPAC Workshop. I find myself realizing (a bit guiltily, I confess!) how little political awareness most of us have of the important part we should be playing for medicine's sake and for the preservation of quality health care. I have a feeling, Jane, that your deep convictions, your enthusiasm, your political sense, will be rubbing off on the rest of us!

Mother of Year

Mrs. Howard Minor of Steubenville, wife of a surgeon, mother of four and grandmother of four, is the 1972 Ohio Mother of the Year. She is very active in innumerable community activities and spearheaded restoration of the first federal land office in the Northwest Territory which is now a public museum in Steubenville. In 1968, the Minors volunteered their services to an injections program and traveled in rural areas of Costa Rica for three weeks giving smallpox vaccinations. They provided similar services in Guatemala the following year. Our warm congratulations go to you. Mrs. Minor, for your many accomplishments, and for your recognition as Ohio Mother of the year.

County Auxiliaries

My apologies for omitting in this May issue the recent items on your local activities that you were good enough to send me. And for which, believe me, I am deeply grateful. Priority had to be given this month to National Convention in San Francisco and the AMPAC Workshop. Next month's issue will be devoted to YOUR activities, I promise you!



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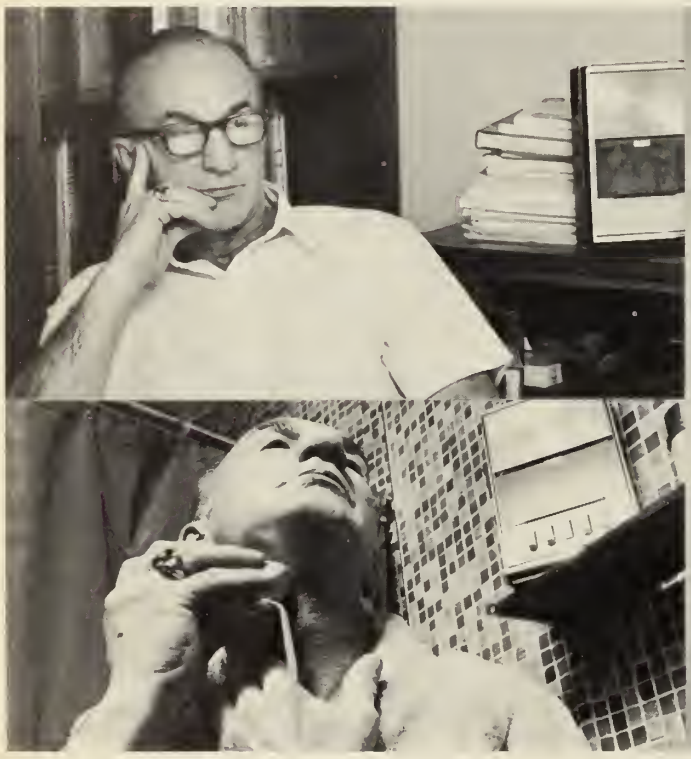
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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The Distribution of Physicians in Northwestern Ohio

Thirty Years' Trends

By Herman W. Reas, M.D.

TWENTY COUNTIES and an area of 8,795 square miles comprise Northwestern Ohio as identified by its Regional Medical Program. In order to gain demographic insight into the problems of physician accessibility which confront approximately 1.4 million residents of this area, the staff of the Northwestern Ohio Regional Medical Program reviewed, county by county, the changes in physician and total populations which have occurred since 1940. We also have examined these changes in the three bordering counties of Michigan.

Methods

1940-1970 population data were obtained for each of the 23 counties studied from official state data supplied us by the Divisions of Vital Statistics, States of Ohio and Michigan. The 1940, 1950 and 1960 physician data for doctors of medicine were taken from the American Medical Association Annual Registries for those years. The 1970 physician data include complete listings of both doctors of medicine and doctors of osteopathy as a result of a triple system of tabulation. First, keypunched MD and DO data were obtained from the American Mailing Service. These cards were cross-referenced with additional sets obtained from Ohio and Michigan rosters of MD's and DO's in the respective state medical and osteopathic associations. Finally, telephone books covering the 20 Ohio and three Michigan counties were reviewed and the MD and DO data abstracted and keypunched. The composite list which resulted was accurate until July 1, 1970.

Doctors of medicine over age 60 were computed from birth dates available from the American Mailing Service cards. We applied the expression, "Not practicing primary medical care," to retired physicians, to physicians filling administrative, research and teaching positions without concomitant participation in hospital bedside or clinic care, to radiologists not providing therapy and to pathologists.

Results

In 1940 there were about 1,355 physicians in Northwestern Ohio. Between 80 to 85 of these were doctors of osteopathic medicine, the majority of which practiced in either Lucas or Erie County. Accurate figures for 1940 are not available for the number of physicians over age 60 or for the number who were not practicing primary medical care. Nonetheless, by excluding known pathologists, radiologists and exclusively administrative physicians from the 1940 figure we can estimate that 1,304 physicians provided the primary medical care of 977,000 people. The uneven distribution of those physicians favored Lucas, Erie, Huron, Allen and Logan Counties.

As of July 1, 1970, 1,422 doctors of medicine and doctors of osteopathy provided primary medical care for 1,386,000 people. Twenty-four percent of these physicians were over 60 years of age. Over the course of 30 years the uneven distribution of physicians worsened in favor of the cities. All Northwestern Ohio counties have experienced relative decline in their numbers of physicians while Allen, Erie and Lucas have retained better physician/patient ratios than the others. Consistently throughout this time span, Toledo and Lima have had most access to primary medical care within the Region. Only the city of Lima has experienced a relative as well as an absolute increase in number of physicians since 1940. Decline in availability of primary medical care is not limited by our northern state border, as is witnessed by similar physician shortages in the adjacent Hillsdale, Lenawee and Monroe Counties of southern Michigan (see Table 1).

The current distribution of physicians within the greater Toledo area was also examined and

Dr. Reas, Toledo, is Deputy Coordinator of the Northwestern Ohio Regional Medical Program and Assistant Professor of Clinical Pediatrics, Medical College of Ohio.

Supported by the Northwestern Ohio Regional Medical Program.

Submitted August 16, 1971.

is reported in Table 2. As in most cities, there is a markedly uneven distribution of primary physicians' offices in Toledo. Here and in Table 3, which relates the regional to the national situation, patient/physician ratios are expressed in the more common form of number per 100,000 population.

Discussion

The widely publicized need for physicians in America stems from three well acknowledged, major phenomena operating together: 1) rapid growth of population; 2) increased use of personal medical services, and 3) the increase in the number of physicians required for rendering specialized services. While the Regional Medical Program Service cannot address itself to the provision of more physicians, it tries hard to address itself to the improvement of physician effectiveness. In conducting this study our purpose was to justify search for and trial of mass medical testing and recording systems having good potential for early disease detection while conserving physician practice time. Identification of such systems is impossible without the physicians first trying them.

Table 1. Patient/Physician Ratios, Northwestern Ohio and Southern Michigan; their expansion over a 30 year period.

County or City	Patient/Physician Ratios 1940	1970	Expansion of Ratio over 30 years
Williams	812/1	1185/1	1.45
Fulton	960	1390	1.45
Lucas	630	672	1.06
Defiance	1500	1565	1.07
Henry	959	1500	1.57
Wood	913	1500	1.64
Ottawa	960	1695	1.77
Sandusky	977	1168	1.20
Erie	614	919	1.50
Paulding	937	2000	2.13
Putnam	926	1668	1.26
Hancock	911	1090	1.20
Seneca	857	1118	1.30
Huron	607	1538	2.54
Van Wert	1125	1380	1.22
Allen	695	974	1.40
Hardin	794	1250	1.58
Mercer	1130	1842	1.62
Auglaize	778	2000	2.57
Logan	698	1240	1.78
Toledo	547	572	1.05
Lima	537	587	1.09
Hillsdale	879	1850	2.11
Lenawee	899	1430	1.59
Monroe	1052	2223	2.12

In Northwestern Ohio and Southeastern Michigan, relatively diminishing numbers of physicians vary considerably in relation to local populations. Predominantly rural counties disproportionately have fewer physicians than does predominantly metropolitan Lucas County. The overall disproportion between rural and metropolitan physician densities has increased by 60 percent during the past 30 years but the stresses produced by such redistribution is diminished by current transportation resources. The onset of this redistribution occurred prior to the time period examined. The rate of redistribution has been excessive for explanations based on death disestablishing practices and preference of new practitioners; there also has been local migration of physicians from smaller to larger population centers. Within cities the density of physicians again is by no means uniform as is exemplified by their distribution in Toledo (see Table 2). Hardly novel or peculiar to our region are these observations; such trends continue throughout the United States. Yet, of in-

Table 2. Distribution of Primary Physicians Within the Greater Toledo Area (April 1, 1971).

	Inner City 91,000 Pop.	East Toledo Oregon 57,300 Pop.	Ottawa Hills Westgate 50,200 Pop.	North End Point Place 46,300 Pop.	West Toledo 95,500 Pop.	South End MCOT 64,000 Pop.	Perimeter of Toledo 67,300 Pop.
AREA ZIP CODES	43601 43602 43603 43604 43608 43610 43620 43624	43605 43616	43606 43607 43623	43611	43612 43613	43609 43614 43615 43617	43460 43528 43537 43551 43560 43566 43571
M.D. Total	247	58	497	17	62	152	69
Family Practice*	77	50	163	17	43	67	49
Pediatrics	3	0	25	0	4	8	0
Neuropsychiatry	10	0	38	0	0	6	1
Ob-Gyn	19	2	33	0	2	12	7
D.O. Total	18	7	4	2	7	11	5
Family Practice*	9	7	4	2	7	11	5

*Includes 100% of General Practitioners' and 75% of Internists' Time.

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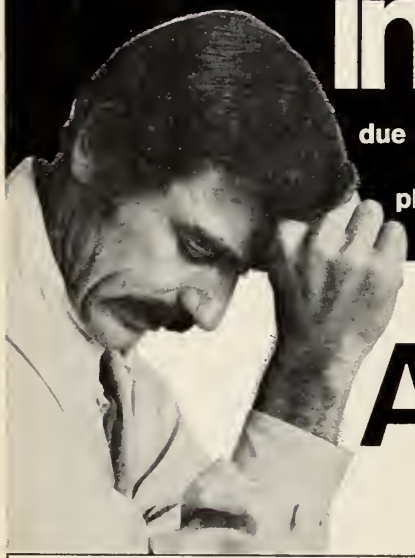
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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sex impotence. Clin Med 12 69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestostero thyroid compound. West Med 5 67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impoten Gen Prac 25 5, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 9 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogene J Urol 79 863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Ph delphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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terest is the fact that the distribution of our physicians varies within a smaller range than that currently experienced elsewhere in Ohio (e.g., the southwestern sector) or in other states.[5]

The famous Bane Report to the Surgeon General (USPHS) in 1959[5] pointed to stability of regional differences with the exception of declining ratios of physicians to populations in the North Central States. Ohio, an East North Central State, typifies this trend. Figures available for active nonfederal physicians (M.D. and D.O.) in Ohio indicate the decline since 1957 to be from 123/100,000 to a present figure of 97/100,000.[5] Revision of our figures to a comparable base indicates that Northwestern Ohio fares slightly better than the state as a whole. Capitating our M.D.'s and D.O.'s regardless of the nature of services rendered by them reveals a regional decline from 137.5 - 138.9 physicians per 100,000 population* in 1940 to 108.6-110.9 per 100,000* in 1970. Correction of this description to the real (i.e., more sparse) situation requires consideration of the types of medical services rendered, knowledge of the demands for these services and knowledge of the ages of physician providers. Our study is not detailed enough to provide these corrections. Even without them, our county and intra-city Toledo data indicates severe shortages of primary physicians within many sectors of our region. Furthermore, our data strongly suggests an aging physician population. Simple replacement within ten years of the 24 percent over age 60 probably would require 35 new physicians per year despite their individually greater work capacity.

Our purpose in publishing these observations is to draw additional attention to the ominous fact that the relative number of physicians in Northwestern Ohio has continued to decline over the past 30 years. Quite probably this decline will continue at least several more years before the increased enrollment in long established and the enrollment in newly established medical schools brings local relief. Concurrent redistribution of physicians has placed considerable stress upon our rural and poor urban populaces as well as reciprocal stress upon the physicians remaining to serve them. An areawide response to Ginzberg's maldistribution thesis[6] could only provide partial relief of our physician deficit. Paxton's statement[7] that our great doctor shortage is ending does not apply to Northwestern Ohio.

A social phenomenon of our time, shunning hamlets for lure of the cities, is neither peculiar to physicians in Northwestern Ohio nor to physicians in the United States as a whole. The Philippines, only large nation in the world with a substantial physician surplus, exemplifies the fact that quantity alone does not solve the problem of physician distribution. With the differences in "way of life" between a large Philippine city and remote village being far greater than is true anywhere in this country, 53 percent of their total registered physicians are not practicing at all rather than practice in the remote, rural areas.[8]

Naturally, we look to the students of Ohio's medical schools for help in reversing the decline in supply of primary medical care in Northwestern Ohio. A study of medical school alumni published in 1967[9] revealed that 50.2 percent of graduates of public medical schools remained to practice in their state of graduation.

*Range of means, our data and references 1-4.

Table 3. Numbers of Physicians in the United States as a whole compared with numbers of Physicians in Northwestern Ohio.

Year (July 1)	Doctors of Medicine[1,2] Rate per 100,000 U.S. Pop.	Rate per 100,000 NWO Pop.	Doctors of Osteopathy[3,4] Rate per 100,000 U.S. Pop.	Rate per 100,000 NWO Pop.
1940	132.6	130.6	9.4	8.3
1950	134.7	102.8	8.5	8.6
1960	132.7	102.4	8.0	8.7
1970	131.0	101.4	8.3	9.5

Acknowledgements

Gratitude is expressed to G. Robert Tittle, Jr., M.D., for use of his data on the distribution of physicians within the Greater Toledo Area; to Thomas Blakowski, director of Media Services, The Toledo Hospital, for photography of graphs accompanying the original manuscript, and to Lucille M. Wayton for preparation of the manuscript.

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Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

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PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

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Skin and mucous membranes—Skin rasl urticaria, vaginitis, and rare instances of foliative and vesiculobullous dermatitis h been reported. *Liver*—Although no direct lationship to liver dysfunction is establis jaundice and abnormal liver function t (particularly serum transaminase) have b observed in a few instances. *Cardiovasc* —Instances of hypotension following pa teral administration have been repor particularly after too rapid IV adminis tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adr istered IV, dilute in 500 ml of fluid administer no faster than 100 ml per h *Special senses*—Tinnitus and vertigo h been reported occasionally. *Local react* —Excellent local tolerance demonstrate intramuscularly administered Linc (lincomycin hydrochloride). Reports of following injection have been infrequ Intravenous administration of Lincoci 250 to 500 ml of 5% glucose in dist water or normal saline has produced local irritation or phlebitis.

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The Romance of Medicine

An Experience in Community Practice for OSU Medical Students

By William R. VanGieson and John A. Burkhart, M.D.

BETHESDA HOSPITAL and Good Samaritan Medical Center, both in the city of Zanesville, sought to participate for the first time this year in Phase I of the Ohio State University College of Medicine's new curriculum for future physicians, "The Romance of Medicine." We joined hospitals in Newark, Lima, Lancaster, and other Ohio cities involved in this newly conceived program which saw its inception in 1970. As a result of the reactions of the students who participated in the program here and the success we believe we achieved, herein follows a description of our development and organization of "The Romance of Medicine" in Zanesville and Muskingum County.

Bethesda Hospital has a complement of 325 beds while Good Samaritan has 523 beds. Both hospitals share almost identical medical staffs with most specialities represented. Patients served by the hospitals and their medical staffs come primarily from throughout a nine-county area of Southeastern Ohio. With this large and heterogeneous mixture of patients, it was felt that the students would have ample opportunity to observe diverse clinical practices and problems.

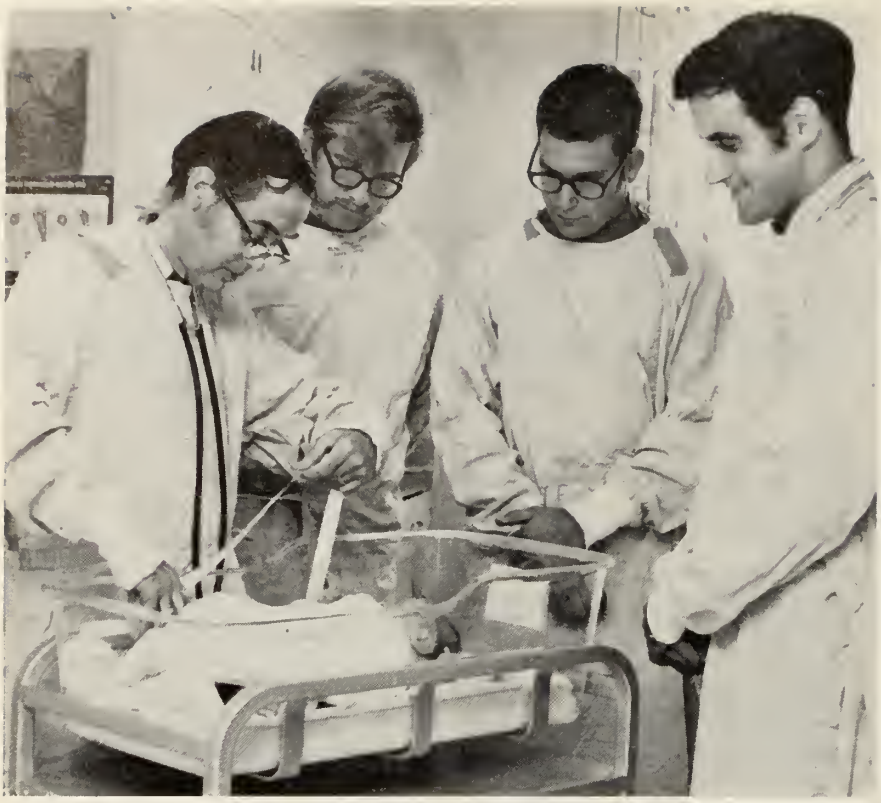
The first question requiring an answer, of course, was whether or not to participate in the program. While this decision would not have been as much of a problem in other larger urban areas where the physician/patient ratio is much higher, it did force serious thought here where 90 physicians serve an area with a quarter of a million people. Working with a medical student, or even a new partner in practice for that matter, does require extra time — time that is precious when a doctor is seeing 30 to 50 patients per day during office hours, and some as many as 75 and more, as well as making rounds or perhaps performing surgery in two hospitals. While many of us feel that all physicians are interested in teaching and want to have a role in it, the time consideration was a major obstacle. However, it was decided that the program would be very worthwhile and that Carl E. Spragg, M.D., immediate past Chief of Staff at Bethesda Hospital, would write to Dr.

Mr. VanGieson is assistant administrator, Bethesda Hospital, Zanesville.

Dr. Burkhart is chief resident, department of physical medicine, Ohio State University College of Medicine, Columbus, and member of the medical staff of Bethesda Hospital, Zanesville.



This panarama view shows OSU medical students who participated in the "Romance of Medicine" project in Zanesville. From left, Richard Essy, John Fiedel, Jeff Black, Randy Hostedt, Jeff Rabinovitz, Gail Peters, Rich McClead, Mike Meaglier, Bob Finelli, Ron Grimwood, Larry Broda and Tom Franklin. Not present for the photo was Mark McGannon.



R. B. Morrison, M.D., chairman of pediatric services at Bethesda Hospital, Zanesville, demonstrates to Ohio State students Rich McClead and Ron Grimwood. On the right is Norman Fogle, medical student of Indiana University on a SAMA project.



R. D. Bateman, Jr., M.D., left, and C. R. Donley, M.D., right, discuss the Zanesville community project with students Larry Broda, Gail Peters and Jeff Black.

Ernest Johnson, Phase I director, about Zanesville being a participating city.

This carried us right into another question: Should the program be undertaken by the Muskingum County Academy of Medicine or by Bethesda Hospital and its Medical Staff? Because the County Medical Academy had already embarked upon a program in conjunction with the Student American Medical Association ("Medical Education with a Community Orientation"), Bethesda and its Medical Staff chose to be the primary instigator of participation. However, because of the need to involve a number of physicians, the hospital administration worked closely with E. R. Haynes, M.D., president of the County Academy to assist in recruiting physician participants.

Scheduling Patterns

The next step was the actual securing of commitments from physicians. Because the program was set for July, there were scheduling problems due to vacations and coverage. The hospital administration and Dr. Haynes presented the proposal to the Medical Staff at one of its regular meetings seeking volunteers to act as preceptors. Although we met some initial resistance because it meant additional demands on their time, we were able to get a sufficient number by continuous efforts and persistent reminders that they were needed to make the program a success. In order to provide for the 12 students we had requested, we needed 15 physicians. When the program began, we welcomed 13 students and had 17 preceptors available.

We then embarked upon the actual scheduling of the rotation pattern. At the inception of "The Romance of Medicine" program at Ohio State in 1970 and in our preliminary thinking, it was planned to assign one student to the same physician for the entire three week, six day duration of the program. Following discussions with Dr. John Burkhart, resident in Physical Medicine at Ohio State and our liaison with Dr. Johnson, we felt there was a better way to expose the students to the practices of community medicine.

We at Bethesda sought to establish as much as possible a rotation whereby the students would spend two days with each of three physicians, each one having a different type of practice. For example, one student would spend two sessions with an internist, two with a general surgeon, and two with a general practitioner. Another would be with a thoracic surgeon, a pediatrician, and an eye, ear, nose and throat surgeon. Still another would be assigned to an orthopedist, an anesthesiologist, and a cardiologist. While we were unable to do this completely, no student had the same physician



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more than two sessions. Since we did not know the names of any of the students who would be coming, we assigned them numbers and simply planned to swap the numbers for names at the time of their arrival the first day. We constructed a block schedule assigning those numbers to the various physicians.

Shadowing Their Preceptors

What did these students do during their days with the physicians? Upon arrival at about 9:00 a.m., they met their preceptors either in their offices or at one of the hospitals. From that time until the end of their day (around 4:30 p.m.), they were with their preceptors continuously. Some students took histories and did physicals in the offices, reporting the results to the physician, some scrubbed in for surgeries, and some even sutured, but all had the opportunity to see the "Practice of Medicine." They were, in essence, the shadows of their preceptors.

Transportation nearly became a major logistical problem. Since 12 students were to be involved, we had expected a small Ohio State University bus but it was cancelled and the students arrived in car pools. Some students were to meet their preceptors at Bethesda, some at Good Samaritan, and some at the physicians' offices. While most of the offices were within walking distance of Bethesda, the trip to Good Samaritan and some other offices necessitated a drive. In any event, these problems were overcome and transportation was adequately worked out among the students themselves.

The final day of the program was devoted to a delayed orientation session as well as a critique of the students' experiences. The orientation was designed to enhance their overview of the hospital as a total institution with a large and varied range of services. In the critique, we hoped to find out what we could do to improve our program next year.

The overview involved presentations by the administrator, assistant administrator in charge of finance, chief pharmacist, and director of social service, as well as case presentations by Dr. Burkhart. They discussed their roles in the hospital and how they cooperate with the Medical Staff. We felt that this might well be their only exposure to these areas before entering into practice as physicians and at least a minimal knowledge of these areas was of importance to them in pursuing a career in medicine.

Seeing the Patients

Two case presentations by Dr. John Burkhart seemed quite interesting to the students. Two former Bethesda patients, one of whom had been



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transferred to Dodd Hall, were presented. One was a young man, 20 years of age, who had been in an automobile accident which resulted in quadriplegia. The other was a 72 year old man who was a bilateral above-elbow amputee with a fractured hip. These cases provided the students with an insight and understanding of patients' attitudes and the importance of the coordination of a broad range of community service agencies in the continuity of patient care.

Following these morning presentations, a luncheon was held to talk over experiences. In addition to the students and the Bethesda hospital administration, the luncheon was attended by many of the preceptors.

Throughout the critique the students asked highly relevant, important, timely questions. They were concerned about the rising costs of health care, duplication of services, preventive medicine, health maintenance organizations, national health insurance, foundations for medical care, and so on. The various hospital staff members tried to present them with the pertinent facts on both sides of their questions letting the students develop their own opinions.

The critique proved to be very worthwhile and bore out our preconceived opinion that a rotation through different types of practices was more desirable for the students than having all sessions with the same physician. All of the students expressed their satisfaction with the smoothness of the program and its organization. They felt it was a very worthwhile experience and believed they were fortunate to be able to observe clinical medicine prior to entering into their academic studies. These first impressions should be lasting ones.

The members of the two hospitals' Medical Staffs who participated as preceptors were also pleased about being a part of the program. They felt it was also an education for them, causing them to think more often about the "whys" of their treatment. Furthermore, it provided them with an excellent opportunity to play an active role in the education of future physicians while being 60 miles removed from the university teaching setting. These physicians and others are looking forward to participating again next year.

The program in Zanesville, then, was successful for all. It provided the first year medical students an opportunity to see hospitals as a complete range of services, not simply as patients, beds, nurses and physicians. It also provided a realistic picture of the "Practice of Medicine," the psychosocial problems of illness, total patient care, and all the things that make up "The Romance of Medicine."



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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ADAMS
Chung K. Ryu
West Union

CRAWFORD
Jorge Riberio
Crestline

CUYAHOGA (Cleveland except as noted)
Mahmoud H. Adam
George M. Awais
Arturo S. Basa
Robert B. Benyo
Ela B. Bhimani
Emmanuel L. Bravo
Dennis B. Brooks
Richard I. Burton
Chalit Cheanvechai
Richard G. Chenoweth
Mary M. Clough
Aniceto Dominguez
Thomas E. Driscoll
Howard C. Filston
Bruno Gebhard
Larry D. Hammerberg
Edith Harrow-Evangelista
North Olmsted
Noor-Ul Hassan
Prakash K. Khandekar
Floyd D. Loop
Sanford S. Luria
William L. Macon IV
Walter A. Mandell
Marilyn E. McDonald
Beno Michel
Moises Moschkovich
Benjamin F. Pinto
Julio Popovsky
Ronald L. Price
Robert H. Redus, Jr.
Wayne Siegel
Willard D. Steck
Constance S. White
Gerald M. Yoswitz

ERIE
Khalid Mahmood
Sandusky

FRANKLIN (Columbus except as noted)
Robert Brownlee
Basappa Byakod
Lucia E. Ciurea
Worthington
Frederick H. Davidorf
Charles Michael Downey
Thomas W. Evans, Jr.
Leland M. Giddings
Worthington
David P. North
James J. Powers
Gary R. Wise

GALLIA
G. Randolph Hand
Gallipolis

HAMILTON (Cincinnati except as noted)
Yunjo Chung
Joseph V. Cresci, Jr.
Robert S. Daniels
Edward V. Ferrara
William D. Fullen
Kenneth N. Hehman
Ft. Thomas, Ky.
Hubert E. Huckel
Robert Norman Ligo
Robert Maltz
Antonio Marquez
Gabriel Marshak
Jacqueline L. Miller
Leonard J. Singerman
Mohendra Sud
Lawrence M. Unger

LAWRENCE
Patrio Tismo
Ironton

LUCAS (Toledo)
Josefina Garcia
John H. Hasley
Michael J. McNamara
Jack L. Mulligan

MAHONING (Youngstown)
Joseph S. Gregori
Yiechul Jung
Dong Sung Lee
George L. River

MONTGOMERY (Dayton)
Harold I. Amory
Jan E. Bernie
David J. Brecourt
D. Kiefer Campbell
Donald B. Hite
Emanuel Kauder
A. Steven Pirnia
Edward Sachs, III
Sukhdev R. Singla
George E. Thomas

PICKAWAY
Charles R. Hedges
Circleville

PIKE
Paul S. Yocum, Sr.
Waverly

PORTAGE
George J. Prochnow, Jr.
Kent

RICHLAND (Mansfield)
Joseph A. Baddour
James D. Curry

ROSS
Edward Y. Su
Chillicothe

SENECA
Mohammad Anvari-Hamedari
Fostoria

STARK
Melanio H. Paulino
Massillon
Guillermo Zaldivar
Canton

SUMMIT (Akron except as noted)
Seung Bong An
Abolfath B. Ardalan
Barberton
James F. Grow, Jr.
Ft. Benning, Ga.
Sheila Kashkari
Gary R. Peterson
Ft. McClellan, Ala.
William R. Roush
Muzaffer Sofuoglu

TRUMBULL (Warren)
Artemio Dangaran
Vincent Demacopoulas

WASHINGTON
Jose C. Alba
Marietta

American College of Surgeons San Francisco Meeting Set

The 58th annual Clinical Congress of the American College of Surgeons will be held in San Francisco, October 2-6. Headquarters will be the Fairmont Hotel.

The program will include 16 postgraduate courses accredited by the Council on Medical Education of the American Medical Association; more than 250 research-in-progress reports; some 50 panel discussions and symposia in general surgery and the surgical specialties; seven operative telecasts from San Francisco General Hospital, and many other features.

The Clinical Congress is open to all doctors of medicine. For additional information, rates, registration and housing forms, etc., contact American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

MDs in the News

Dr. Benjamin B. Caplan, Columbus, was given the "Physician of the Year" award of the Ohio Nursing Home Association at the organization's recent convention. To date Dr. Caplan has received some 21 awards and honorable recognitions from various organizations and governments for his humanitarian efforts in medical and health programs at home and abroad.

The Summer Program in Human Sexuality, sponsored by Indiana University is scheduled for July 16-27. For details write before June 24 to: Summer Program, Institute for Sex Research, Indiana University, Bloomington, Indiana 47401.

Dr. Raymond R. Suskind, Cincinnati, is one of five physicians named to the Board of Directors of the Industrial Medical Association at the organization's 57th annual meeting held recently in Philadelphia. He is professor and chairman of the Department of Environmental Health at the University of Cincinnati College of Medicine.

Dr. and Mrs. Orville Layman were named as Franklin's "Citizens of the Year" at the 25th annual awards banquet of the local Chamber of Commerce. The Laymans have lived in the southwest Ohio community since 1933 and Dr. Layman has practiced in the area since then with the exception of World War II years when he was in service.

Dr. William H. Havener recently was promoted to the chairmanship of the Department of Ophthalmology at Ohio State University, effective July 1. A member of the faculty since 1954, he succeeds Dr. Torrence A. Makley who will resume full-time teaching and research duties in the department.

Symposium on the Newborn

The Department of Pediatrics, University of Louisville School of Medicine will present its sixth annual symposium on the newborn, November 2-3, to be held at the Health Sciences Center Auditorium, Louisville, Ky. The subject this year is infections in the newborn.

For additional information, write: Billy F. Andrews, M.D., Professor and Chairman, Department of Pediatrics, 226 East Chestnut Street, Louisville, Ky. 40202.



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Internist Groups Call Off Amalgamation

The proposed amalgamation between the American Society of Internal Medicine and American College of Physicians has been called off.

The mutual decision was reached by the ASIM-ACP Liaison Committee when it met April 18 during the groups' annual sessions in Atlantic City.

A joint statement signed by Edwin Evans, M.D., president of the 12,000-member ASIM, and William Sodeman, M.D., president of the 20,000-member ACP, declared:

"Since the announcement on March 27, 1972, of the intention of the American College of Physicians and the American Society of Internal Medicine to form a new single organization, there has been further discussion by their respective governing bodies at their annual meetings.

"It was decided that it is not feasible at the present time to amalgamate the two groups. Under these circumstances, liaison between the two organizations is essential and will continue."

The Annual Otolaryngologic Assembly of 1972, sponsored by the Department of Otolaryngology of the University of Illinois, will be held October 14-20 in the Eye and Ear Infirmary of the University of Illinois Hospital. Interested otolaryngologists should direct their inquiries to the mailing address: Otolaryngology, P.O. Box 6998, Chicago, Illinois 60680. A course in laryngology and bronchoesophagology will be given November 13-18.

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"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Would it be useful in clinical practice to have government predetermine drugs of choice?

Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

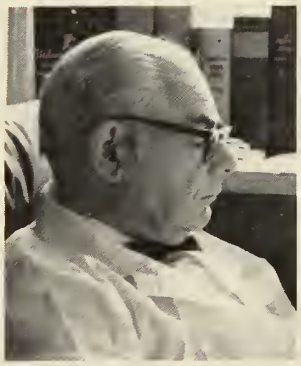
86.7%
No, it would not be useful.

Dialogue

Would it be useful in clinical practice to have government predetermine drugs of choice?

Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really determined.

The Bureau of Drugs suggested the package sert as a possible means communicating informat on relative efficacy of dr to the physician. I find t objectionable, since I not believe the physic should have to rely on t source for final scient truth. There is also a pr tical objection: Since physicians actually c pense drugs, they selc see the package insert. any event, I would ma tain that the physic should know what drug wants and why without pending on the governm or the manufacturer to him.

Undoubtedly, physici are swamped by exces numbers of drugs in s therapeutic categories. I am well aware that m drugs within such ca gories could be elimina without any loss, or haps even some profit the practice of medic But, in my opinion, nei the FDA nor any o single group has the ex tise and the wisdom ne sary to determine the "drug of choice" in areas of medical practi

Maker of Medicine

neth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
li Lilly and Company



n my opinion, it is not unction of any governt or private regulatory cy to designate a "drug oice." This determinashould be made by the sician after he has red full information on properties of a drug, then it will be based on experience with this ; and his knowledge of individual patient who eking treatment.

an evaluation of comtive efficacy were to be e, particularly by govnent, at the time a new is being approved for keting, it would be a t disservice to medi- and thus to the patient consumer. For exampwhen a new therapeugent is introduced, on basis of limited knowl-, it may be considered e more potent, more ctive, or safer than lucts already on the ket. Conceivably, at time the new drug d be labeled "the drug hoice." But as addiil clinical experience is mulated, new evidence become available. r, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B_{12} as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use — information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

Opinion & Dialogue

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Clinical & Scientific Features



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Abstracts from Regional Meeting of American College of Physicians

EDITOR'S NOTE: Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Western Pennsylvania, Ohio, and West Virginia, November 12-13, 1971, at the Montefiore Hospital, Pittsburgh, Pennsylvania. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. John B. Hill and his Program Committee for the selection of the papers and to them and the Governors of the College for Western Pennsylvania, Ohio, and West Virginia for permission to publish the abstracts.

* * *

Salivary Electrolytes in the Diagnosis of Digitalis Intoxication

Martin I. Broder, M.D., and Louis Rakita, M.D., F.A.C.P., Cleveland, Ohio

Determination of salivary K^+ and CA^{++} has been proposed as a diagnostic test for digitalis intoxication. In this study, saliva was collected from normals and from non-toxic controls either on digoxin only or digoxin plus a diuretic. Normal saliva K^+ and CA^{++} values (meq/1) were 1.8 ± 2.4 ($M \pm S.D.$) and 3.2 ± 0.9 respectively. Digoxin controls had values of 22.1 ± 4.9 and 3.9 ± 1.7, with levels of 23.5 ± 3.7 and 4.5 ± 1.2 in digoxin-diuretic controls. Azotemic patients showed an extremely wide range of salivary K^+ and Ca^{++} levels and were excluded. In 12 cases of digitalis intoxication, saliva K^+ was 28.3 ± 3.2 (p 0.02) and saliva CA^{++} was 4.8 ± 2.7 (p NS). The K^+ values were abnormal in eight instances and the CA^{++} values abnormal in three cases. In an additional 26 patients in whom digitalis intoxication was suspected but not proven, salivary K^+ and CA^{++} were normal in 24 and showed elevated Ca^{++} in two cases. The serum K^+ and Ca^{++} were normal in both groups of patients, except for one toxic patient with hypokalemia, whose salivary K^+ was nonetheless elevated.

These data suggest that the determination of salivary K^+ in nonazotemic patients may be helpful in diagnosing digitalis intoxication, although some overlap with normal values may occur. Salivary Ca^{++} levels are more variable and do not separate toxic from non-toxic patients.

(More abstracts on next page)

Recognition of Digitalis Intoxication in the Presence of Artificial Pacemaker Rhythm

Edward K. Chung, M.D., F.A.C.P., Morgantown, West Virginia, and Donald K. Chung, M.D., Clarksburg, West Virginia

Cardiac arrhythmias alone, instead of the more classical symptoms such as gastrointestinal, are often the first and only manifestation of digitalis intoxication (DI), especially with the purified glycosides. Faced with the artificial pacemaker rhythm (APR), the presence of DI may be particularly difficult to recognize, because certain digitalis-induced arrhythmias (ie, AV block) may be concealed. The purpose of this paper is to improve diagnostic acumen of DI in patients with artificial pacemaker by reporting our experience with 20 such patients. All patients had coronary and/or hypertensive heart disease. Age ranged from 59 to 80 years and 14 were older than 70 years. All but two patients were male.

AV junctional escape rhythm was found in three cases (15 percent) and nonparoxysmal AV junctional tachycardia was present in five patients (25 percent). Two patients developed atrial tachycardia. The remaining ten patients (50 percent) had ventricular premature contractions (VPC). The clue to the diagnosis of DI is the onset of changing atrial activity, particularly the appearance of retrograde P waves in the presence of APR during digitalization. Otherwise, a recognition of VPC is extremely important. Thus, a careful analysis of electrocardiogram is essential because clinical manifestations of DI may be totally lacking or difficult to interpret particularly in elderly individuals.

AV junctional arrhythmias in the presence of APR are almost pathognomonic of DI; they must be looked for carefully since they could easily be overlooked.

* * *

Congenital Coronary Arterio-Venous Fistula

Jasbir S. Makar, M.D.; Don L. Fisher, M.D.; Frank R. Begg, M.D., F.A.C.P.; and Manuel I. Salvoza, M.D., Pittsburgh, Pennsylvania

Congenital anomalous coronary arterial communications with cardiac chambers or with the great vessels, though uncommon, are clinically important. They may be the site of bacterial endarteritis; they may manifest or provoke pulmonary hypertension or congestive heart failure; or they may cause angina pectoris because of a coronary steal syndrome. They should be distinguished from other causes of continuous murmur over precordium, and ideally they should be surgically corrected and permanently cured. Five cases are presented where the origin and termination of the fistulous communication have been visualized by selective coronary arteriography or by powered injection into the root of the ascending aorta. One case had subacute bacterial endarteritis which was treated with antibiotic therapy, and surgical correction is to be done in the near future. One patient has chest pain possibly due to a coronary steal effect. The others have asymptomatic murmurs.

* * *

The Effects of Baseline Lipid, Glucose, and Insulin Levels and Phenformin Treatment on Coronary Mortality

Richard Reynertson, M.D., and Manuel Tzagournis, M.D., F.A.C.P., Columbus, Ohio

The influence of hyperlipidemia and hyperglycemia on mortality is unknown in patients with established coronary disease. These metabolic factors are known, however, to increase the risk of developing coronary heart disease. We investigated the influence of baseline glucose, insulin, and lipid levels, and the effect of phenformin on mortality in patients with known coronary disease.

A total of 141 patients were followed after recovery from a coronary event between 1965 and 1970. They were below the age of 50 years and were not known diabetics previous to entering the study. Glucose tolerance tests with insulin measurements and lipid levels were determined initially and at regular intervals for up to 66 months. All subjects entering the study during the first year were treated with phenformin. For the next four years, each new patient was randomly assigned to a treatment group of diet alone or phenformin plus diet.

During follow-up, 23 of the 141 patients (16 percent) died. The mean glucose area (during the tolerance test), insulin area, and triglyceride levels of the 23 patients were not significantly different from those of the 118 survivors. The mean initial cholesterol of those who died was 353 ± 16 (SEM) compared to 300 ± 8 ($p < .05$) in survivors. Cumulative life-table survival showed no significant difference in any of the five years between patients taking phenformin and those on diet alone.

With the possible exception of cholesterol, baseline glucose tolerance, insulin, or lipid characteristics did not seem to influence mortality once coronary disease had been manifested. Furthermore, mortality in these high risk patients was not affected by phenformin.

* * *

Beta-Adrenergic Blockade in Hypertension: Practical and Theoretical Implications of Long-Term Hemodynamic Variations

Robert C. Tarazi, M.D., and Harriet P. Dustan, M.D., F.A.C.P., Cleveland, Ohio

Availability of propranolol has allowed a practical evaluation of cardiac factors in hypertension. Its antihypertensive effectiveness, therefore, was evaluated in 52 patients, especially as regards the relationship of cardiac output (CO) variations to blood pressure control, selection of patients for therapy, and transient hypertensive responses to office visits and similar stimuli. Repeated hemodynamic studies were performed before and during chronic propranolol treatment and in all, efficacy of beta-blockade was demonstrated by inhibition of chronotropic response to isoproterenol infusion. Four patients discontinued propranolol because of side-effects; among the rest, mean arterial pressure (MAP) was reduced in 26 patients and unchanged in 22. MAP responses could not be predicted from initial hemodynamic studies; though increased CO (>3.3 L/m/M^2) was more frequent among responders than nonresponders (59 percent vs 37 percent), group averages were not significantly different. Treatment reduced CO in both groups, so that MAP response was related to changes in total peripheral resistance (TPR) ($r=0.639$, $p<.01$), but not to changes in CO ($r=0.114$). Transient MAP rises over home levels during treatment were always related to increased TPR. Similarly, pressor response to sustained hand grip in seven patients was not diminished by propranolol despite its interference with the CO rise ($p<.01$) associated with static exercise. These results suggest that (a) propranolol is effective in moderate hypertension (26/52 patients) but responders can not be preselected with certainity; (b) long-term pressure reduction, though possibly initiated by decreased CO, is related to variations in TPR; and (c) transient hypertension is not prevented by propranolol's blunting of cardiac output increases.

* * *

Gastroduodenoscopy: A Comparison with X-ray

George J. Brodmerkel, Jr., M.D., (Associate), Pittsburgh, Pennsylvania

The endoscopic findings in 100 consecutive patients who were examined with the new Olympus Duodenoscope (Model JF-B) either before or after upper gastrointestinal roentgenograms are the subject of this report. Written and photographic records were made in each instance. The written reports were then compared for accuracy of diagnosis of both gastric and duodenal lesions.

All of the endoscopic examinations were either performed or checked by the author. On the other hand, x-ray studies were performed by several experienced radiologists as well as residents. Usually, only the spot films taken by the residents were checked by a staff radiologist.

In a small number of cases, lesions of a size which would permit their visualization by x-ray were not detected even though the examiner knew the location of the lesion found at endoscopy.

The comparison of these diagnostic modalities indicates that gastroduodenoscopy yields a more accurate diagnosis. Failure to enter the duodenum (only eight times in 117 attempts), however, favors the accuracy of x-ray study. Duodenal bulb spasm and/or deformity, on the other hand, made x-ray interpretation difficult.

Neither study excludes the other. In view of the obvious advantages of both examinations, their combined and integrated use should yield an accuracy approaching 100 percent.

* * *

Hiatus Hernia, Duodenal Ulcer, and Peptic Esophagitis—Experience with Esophagoscopy

John M. Weber, M.D., F.A.C.P., Centerville Clinic, Fredericktown, Pennsylvania

This paper is based on a personal experience of over 2,000 esophagascopies. Its thesis is that hiatus hernia with gastric hypersecretion is usually a benign condition either asymptomatic or responding to simple conservative measures. Hiatus hernia with gastric hypersecretion with or without peptic ulcer, on the other hand, is a very different problem and has a strong potential for esophagitis and eventual stricture. A complete surgical repair restoring all the normal anatomy is recommended in these cases of esophagitis. Procrastination or neglect of these cases with hiatus hernia and esophagitis will lead in some cases to progressive stricture often requiring much more serious surgery than repair of the hiatus hernia.

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The Effect of Secretin and of Duodenal Perfusion with Acid on Gastric Acidity in Patients with Duodenal Ulcer

James H. Butt, M.D., F.A.C.P., Takasuke Yoshida, M.D., and Bertram Fleshler, M.D., F.A.C.P., Cleveland, Ohio

The gastric hypersecretory state which characterizes human duodenal ulcer disease might be due either to increased stimulation or to decreased inhibition of normal stimulation or both. To assess

possible inhibitor mechanisms, 11 patients with chronic duodenal ulcer disease were studied. In each patient the effects of intravenous (IV) saline (control); IV secretin (boots, two units per kg in four divided doses); and duodenal perfusion with 0.1 N HCl (7 ml/min) or broth-stimulated gastric acid secretion were evaluated. Gastric acid concentration [tested both by titration to pH 4 ("free acid") and to pH 7 ("total acid")] was significantly inhibited (t test, $p<0.001$) by either secretin or duodenal perfusion. Total acidity decreased similarly. Neither the amount of NaOH required to titrate from pH 4 to 7 ("combined acid") nor the volumes of gastric juice differed significantly, indicating that neutralization by reflux of alkaline duodenal contents was not responsible for the observed effects. Furthermore, elimination of periods with greater than 10 percent reflux, assessed by use of a nonabsorbable marker in the duodenal perfusate, failed to alter the effect of duodenal perfusion. The inhibitory effect of duodenal perfusion with acid was significantly less marked (p 0.01 <0.05) than that of secretin. The decreased effect might be due to greater variability in the response to duodenal perfusion than to secretin, but an analysis of variance could only demonstrate significant patient variation without identifying a poorly responding subgroup. The results of this study indicate that failure of end-organ (gastric mucosa) response to secretin does not appear to play a role in the hypersecretion of duodenal ulcer, but that relative failure of release of either secretin or of other inhibitor substances might be a contributing factor.

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HAA Hepatitis in Pregnancy: Evidence Against Transplacental Transmission of Australia Antigen in Early and Late Pregnancy

R. Thomas Holzbach, M.D., F.A.C.P., Cleveland, Ohio

The possibility of intrauterine transmission of the HAA-associated hepatitis virus was examined in three pregnancies. Each of the three trimesters of pregnancy was represented by an instance of maternal HAA-positive hepatitis occurring during that period. Hepatitis-associated-antigen (HAA) and antibody were determined in all sera from the studied cases by the counterimmunoelectrophoretic technique of Gocke and Howe. Fetal liver and other conceptus tissues obtained from a terminated first-trimester pregnancy were homogenized by sonication, centrifuged and tested for HAA by both counterimmunoelectrophoresis and complement fixation. Tests for nonspecific tissue and serum inhibitory substances were also performed. Previously frozen fetal liver tissue was also examined for HAA with a fluorescent antibody technique. Histological examination of fetal tissue failed to show abnormality. Maternal serum in all three studies was positive for HAA only during the active phase of clinical hepatitis, whereas sera from umbilical cord blood and infant from the two instances where specimens were available were HAA negative. Fetal tissues were uniformly negative for HAA with the methods described. Tissue and umbilical cord blood inhibitory substances could not be demonstrated. Including the present observations, a total of 12 instances are now available in which umbilical cord blood testing for HAA has been negative in the presence of recent or concomitant maternal HAA-positive hepatitis or persistent antigenemia. The weight of this evidence suggests that the placenta in pregnancy constitutes an effective barrier to the HAA-associated virus. Previous hypotheses concerning fetal sequellae of maternal hepatitis thus seem unlikely. Accordingly, the data suggest that the occurrence of maternal HAA-positive hepatitis does not solely constitute grounds for therapeutic abortion.

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Clinical Significance of Serum Alkaline Phosphatase (SAP) Isoenzymes Study

Stuart Chen, M.D., and William Anderson, M.D., Morgantown, West Virginia
(Introduced by Edmund Flink, M.D., F.A.C.P.)

Elevation of serum alkaline phosphatase (SAP) activity may be the first or only sign of occult disease involving the hepatobiliary system, skeletal system, intestine, or malignant tumors. Extensive investigation may then be required to establish the significance of the elevated SAP. Separation of SAP isoenzymes by electrophoresis on starch gel, agar gel, cellulose acetate, and polyacrylamide gel slab has been only partially successful.

SAP isoenzymes were successfully separated by disc electrophoresis into liver, bone, and intestinal bands. More than 600 consecutive sera with elevated SAP were studied.

* * *

Gonococcal Arthritis, A Clinical Study

Irving Kushner, M.D., F.A.C.P., Cleveland, Ohio

Sixty-nine patients with gonococcal arthritis were studied over eight years. Gonococci were demonstrated in synovial fluid in 32 percent, in blood in 13 percent, and in the gastrourinary tract, skin, or throat in the remainder, and all responded dramatically to antibiotics. Significant clinical features emerging from the study include: (1) Sixty-

three of the patients were young women, one fourth of them were pregnant, many were without recent sexual exposure or pelvic symptoms. (2) Skin lesions of gonococcemia and tenosynovitis each occurred in one half of the patients and were valuable diagnostic aids. (3) There was a correlation between systemic symptoms and bacteriologic or dermal evidence of gonococcemia. (4) Of 13 patients with mono-articular disease, gonococci were found in synovial fluid in ten. Only one of these patients gave a history of chills and fever. These studies indicate that gonococci are disseminated to joints or tendon sheaths via the blood from pelvic foci in chronically infected asymptomatic women. Most patients show a septic picture, polyarthritis, minimal or sterile joint effusions, and often septic dermal infarcts. A smaller number of patients have asymptomatic bacteremia with presenting complaints limited to acute arthritis, often with mono-articular disease and positive synovial cultures. Awareness of the clinical spectrum of this disease permits accurate diagnosis and prompt therapy, which is invariably successful.

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Caplan's Syndrome

George Kunkel, M.D., (Associate), Centerville Clinic, Fredericktown, Pennsylvania

Caplan's syndrome consists of pulmonary nodulations in the chest roentgenograms of individuals exposed to various forms of dust, in association with overt or latent rheumatoid arthritis. It is one of the variants of rheumatoid lung disease. The chest lesions may be interpreted as neoplasm when, in fact, they are benign lesions. Since Caplan's initial report in 1953, five hundred and fifty cases had been reported in the European literature up to 1963. In contrast, only sporadic reports are noted in the American literature.

Six cases of Caplan's syndrome observed at the Centerville Clinic, in Southwestern Pennsylvania are presented. This syndrome, therefore, may not be uncommon in the United States. Knowledge of this syndrome may spare a patient with this entity an unnecessary thoracotomy or prevent categorizing a patient as a victim of hopeless metastatic disease.

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Four and One-Half Years Experience in Home Dialysis

K. L. Popowniak, M.D., and S. Nakamoto, M.D., Cleveland, Ohio

Seventy patients, 43 men and 27 women, aged 17 to 61 years were dialyzed at home for 1 to 54 months. The primary diseases were glomerulo- or pyelonephritis (45), polycystic kidneys (14), congenital defects (4), nephrosclerosis (3), and others (4). They were selected on a first come, first served basis. Three dialyzers, the Kiil (47), washing machine (14), or Coil (9) were used two to three times per week. Atrioventricular (AV) shunts were used by 45 patients and AV fistulas by 25. The average training period was 10.8 weeks.

The survival rate was 52/70 (74 percent), 37/56 (66 percent), 21/33 (64 percent), and 7/13 (54 percent) for the first, second, third, and fourth years respectively. Twenty-five patients were completely rehabilitated; 11 were employed part-time and two were unemployed. Five patients subsequently received cadaveric kidney transplants. The leading causes of death were cerebrovascular accident (five), cardiovascular disease (three), and sepsis (three). The main complications were hypertension in 39 (55 percent), secondary hyperparathyroidism 23 (33 percent) requiring parathyroidectomy in nine patients, neuropathy in 23 (33 percent), pericardial effusion in 14 (20 percent), and psychiatric problems in 12 (17 percent). They required an average of 1.5 admissions and 16.5 days of hospitalization per patient. The main reasons for readmission were problems related to the shunts and overhydration. The blood transfusion requirement was 1 unit per patient per month. The average life of the AV shunt was 12.3 months.

The annual maintenance cost was $1300 for the Kiil and $3500 for the Coil dialyzer. Home dialysis was found to be a practical, inexpensive, and convenient method of therapy for end-stage renal disease and potential cadaveric transplant recipients.

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A Safe Catheter Replacement Prosthesis Providing Chronic Access to the Peritoneal Cavity for Repeated Peritoneal Dialysis

Robert F. Manning, M.D., and Donald G. Vidt, M.D., F.A.C.P., Cleveland, Ohio

Ten patients with chronic end-stage renal failure have been dialyzed for periods ranging from 58 to 410 days during which time a simple catheter replacement prosthesis has been utilized to maintain a fistulous tract in the abdominal wall for repeated catheter replacement. Prophylactic antibiotics were not routinely utilized. In five patients, no infectious complications were noted and cultures were persistently negative. A total of ten episodes of peritonitis were observed in the remaining five patients. All were successfully treated with appropriate antibiotics. It should be possible,

from the pattern of cultures noted during serial dialyses, to predict the likelihood of infection thus allowing suitable prophylactic antibiotic therapy to be instituted.

Use of the replacement prosthesis has simplified catheter replacement, reduced complications of peritoneal dialysis, and improved acceptability of intermittent dialysis to the patient. Catheter replacement by this method can be performed with ease and safety by paramedical personnel.

* * *

Pulmonary Shunting and Decreased Arterial-Mixed Venous Oxygen Content Difference in Uremia: Effects of Dialysis

Clyde N. Rolf, M.D., (Associate), Lionel R. King, M.D., F.A.C.P., and John W. Verser, M.D., F.A.C.P., Cincinnati, Ohio

This study was conducted in an attempt to identify, if possible, any factors other than anemia that contribute to the marked fatigue state of the chronic uremic. The oxygen content of arterial and mixed venous blood was measured, pre- and post-dialysis, as also were red cell P50 and 2,3-DPG. In seven patients studied so far the values obtained were as follows, in the pre-dialysis state: arterial 0_2 content 10.56 ± 0.627 volumes %. S.E.M. (range 8.12 to 13.86 volumes %): mixed venous 0_2 content 8.89 ± 0.55 volumes %, range 7.93 to 10.88 volumes %, A-$V0_2$ difference 1.68 ± 0.46 (range 0.24 to 3.65 volumes %). Predialysis intrapulmonary shunting, expressed as percent of cardiac output perfusing unventilated lung and calculated while the patient was breathing 100% oxygen, was 50.86 ± 10.43% (range 17 to 86%). Red cell P50, 34.29 ± 1.52 millimeters mercury. (normal 27.80 ± 1.13 millimeters mercury). Red cell, 2,3-DPG 20.30 ± 3.19 micromoles per gram hemoglobin. (Normal 15.44 ± 2.03 micromoles/gm. Hb.)

Eight chronic uremics were studied immediately postdialysis. Arterial 0_2 content was 10.92 ± 0.62 volumes % (range 8.54 to 12.88 volumes %). Mixed venous 0_2 content 7.57 ± 0.65 volumes % (range 5.82 to 9.68 volumes %). A-$V0_2$ difference 3.35 ± 0.74 volumes % (range 1.23 to 5.43 volumes %). Intrapulmonary shunting 26.6 ± 5.6% (range 13 to 44%). Red cell P50 33.40 ± 1.22 millimeters of mercury red cell 2,3-DPG 22.36 ± 3.93 micromoles per gram hemoglobin.

The very narrow A-$V0_2$ content differences suggest a difficulty in delivering oxygen to the periphery, and the postdialysis value was significantly increased over the predialysis level. This is rather surprising in view of the elevated red cell 2,3-DPG and attendant elevated P50 that did not change on dialysis. Though cardiac output data are not as yet available, it is apparent that very marked increases therein would be necessary to even approach delivery of approximately normal amounts of oxygen to the cells of the body. The intrapulmonary shunts cannot help but add appreciably to this difficulty in oxygen delivery. Though the postdialysis data are just below the level of significance in their difference from the predialysis values, the data suggest that an immediate benefit from dialysis of a uremic is a decrease in the amount of intrapulmonary shunting. To our knowledge, significant intrapulmonary shunting as a complication of uremia has not previously been described. The increase in A-$V0_2$ content difference as a consequence of dialysis has likewise not previously been appreciated.

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Surgical Treatment of Unilateral Renal Vascular Disease: Prognostic Role of Bilateral Renal Biopsies

Donald G. Vidt, M.D., F.A.C.P.; Frederick M. Yutani, M.D.; Lawrence J. McCormack, M.D.; Bruce H. Stewart, M.D.; Thomas C. McLaughlin, M.D.; Thomas F. Meaney, M.D.; David A. McEwen, M.D., and Ray W. Gifford, Jr., M.D., F.A.C.P., Cleveland, Ohio

The relationship of renal arteriolar sclerosis (AS) to the operative result has been assessed from a retrospective analysis of 33 patients with unilateral renal arterial stenosis and hypertension. Bilateral renal biopsies were performed in all patients at the time of surgery. AS in the contralateral kidney was present in 9 of 20 patients who had relief of diastolic hypertension and in 9 of 13 patients who failed to respond. AS was severe in four of the former group and three of the latter group. The ipsilateral or "protected kidney" showed minimal or moderate AS in only five patients. In three cases, AS was more severe in the contralateral kidney. AS in the contralateral kidney was present in 8 of 17 patients with atherosclerosis of the main renal artery and in 10 of 16 patients with fibrous disease. It was concluded that the presence or absence of AS is not a reliable index for predicting which patients with renal vascular disease will get surgical relief from hypertension.

* * *

The Effect of Prolonged Upright Posture on the Rhythms of Aldosterone and Electrolyte Excretion

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The aldosterone secretory rhythm has been attributed to a series of the events initiated by changes of posture. This mechanism has been challenged by the recent report of the demonstration of a circadian rhythm of plasma aldosterone during continuous supine posture. To explore further the effects of posture on the rhythms of aldosterone and electrolyte excretion, eight normal subjects were studied during 48 to 72 hour control and 48 to 72 hour *continuous* upright posture periods. They were fed three hourly constant diets, and urines were collected at three-hour intervals throughout the control and upright periods and analyzed for sodium, potassium, chloride, calcium, phosphorus, magnesium, creatinine and 17-hydroxycorticosteroids (17-OHCS). Pooled six-hour urines from four subjects were analyzed for tetrahydro-aldosterone. Sodium and water retention occurred and dependent edema was observed in all subjects at the termination of the upright period. Circadian patterns of excretion (expressed as percent of 3- or 6-hour means for each day) for sodium, potassium, chloride, calcium, 17-OHCS and urine volume were grossly unaffected by continuous upright posture. The magnesium excretory rhythm became disturbed by the end of the first day of upright posture and the phosphorus nadir appeared earlier during the upright period. The tetrahydro-aldosterone excretory rhythm was clearly evident throughout the upright period with peak excretion in the early-to-late morning hours and a nadir between 1800 and 2400 hours. The sodium-potassium ratio also cycled and was a mirror image of the tetrahydro-aldosterone rhythm. The results suggest the presence of an endogenous circadian rhythm of aldosterone secretion independent of changes of posture.

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Systemic Lupus Erythematosus (SLE) in the Elderly

Robert P. Sheon, M.D., F.A.C.P., and Allan B. Kirsner, M.D., Toledo, Ohio

Nine of 86 patients with systemic lupus erythematosus (SLE) were diagnosed after the age of 60 years. They differ from younger patients with SLE in mode of onset, specific organ systems involved, severity of disease, and prognosis. The presentation is insidious rather than acute. Most patients present with myalgia, loss of weight, and fatigue (polymyalgia rheumatica syndrome), or rheumatoid-like arthritis. The clinical course is benign, serositis is less common, the patients are more easily controlled on aspirin or low dose steroids, and the prognosis of SLE in the elderly is relatively good. Because age modifies the clinical expression of SLE the diagnosis can be easily missed if not specifically searched for. Serum should be checked for antinuclear antibody using an indirect immunofluorescent test in all elderly patients with unusual undiagnosed pain syndromes.

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A Comparison of the Staphylococcal Clumping Test (SCT) and Counter Electrophoresis (CEP) in the Detection of MISFI (Molecules Immunologically Similar to Fibrinogen)

J. H. Lewis, M.D., and J. M. Brandon, M.D., Pittsburgh, Pennsylvania

The diagnosis of intravascular coagulation of primary fibrinolysis has become an important clinical problem. Methods for the determination of MISFI have been most supportive in that diagnosis. Recently we reported on the determination of MISFI by a new CEP method. (Fed. Proc. 30:479, 1971). This method was rapid and relatively sensitive. The SCT (Allington, *Brit J Haemat* 13:550, 1967) is not an immunological test but a sensitive, rapid test based on the fact that certain strains of staphylococcus, containing a clumping factor, will clump in the presence of early MISFI (X,Y). The presence of these products in the serum in significant titers supports the diagnosis of intravascular clotting. Both tests have been performed in parallel for comparison. Normal patients, seriously ill patients with and without bleeding phenomenon but without apparent intravascular clotting, and patients with definite focal or generalized intravascular clotting are analyzed. Degradation products were also produced in vitro by enzymatic degradation of fibrinogen and in vivo by the infusion of thromboplastin or streptokinase into dogs. Sensitivity of CEP (20-30 mg/ml fibrinogen equivalents) is good and relates comparably to the clinical picture. The test is positive for all MISFI (X, Y, D, E). Sensitivity of SCT is better but measures only high molecular weight MISFI (X, Y). Normal individuals show no MISFI by CEP, however, 0-15 mg/ml have been found by SCT. "Fast" serum should be used in both tests.

(More abstracts on next page)

Dibromomannitol in the Control of Postsplenectomy Thrombocytosis

S. V. Ramanan, M.D., Morgantown, West Virginia

Thrombocytosis in the splenectomized patient is usually moderate in degree and of transient duration. On occasion however, it may be both severe and prolonged and an urgent reduction in platelet count is mandatory. Busulphan, in our experience, is slow in action and therefore not suitable for use in this condition. Reporting on his experience with five patients using melphalan, Rundles had considerable difficulty in controlling high platelet counts in similar states. We report here the response obtained with the use of dibromomannitol, a drug hitherto used in the treatment of chronic myelogenous leukemia.

A 35-year-old white male presented with splenomegaly, moderate peripheral thrombocytosis, and marked megakaryocytosis of the marrow. Following splenectomy, there was a sharp rise in the platelet count, reaching a maximum of 3.6 million per cu mm. Busulphan was initiated at a dose of 6 mg daily, and because of a continuing rise in the platelet count, nitrogen mustard 0.1 mg was given, with a short-lived drop in the platelet count. A recurrence of the thrombocytosis to earlier levels was again treated with nitrogen mustard with similar response. At this point, the patient was started on dibromomannitol at a dose of 2 mg per kg daily, this being gradually increased to 6 mg per kg daily. The effect was rapid and dramatic, resulting in a thrombocytopenia with a nadir of 18,500 per cu mm 36 days after the commencement of treatment. A gradual rise in platelet count was then observed. At present, the platelet count is well controlled without further therapy. For the most part, treatment has been carried out as an out-patient, with the patient in full employment.

This, to our knowledge, is the first report of the use of dibromomannitol in the control of thrombocythemia.

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Hemolysis In Hereditary Elliptocytosis

Aaron P. Scholnik, M.D.; Charles P. Van Tilburg, M.D.; George C. Hoffman, M.D., B. Chir., M.R.C. Path., F.A.C.P.; and John D. Battle, Jr., M.D., F.A.C.P., Cleveland, Ohio

The cases of four related children with hereditary elliptocytosis are presented, illustrating the variation of clinical manifestations that may be seen in this disorder. Hematologic studies of the family of these patients included peripheral blood films, blood grouping, and the determination of the hemoglobin value, serum bilirubin and haptoglobin levels, reticulocyte count, and hemoglobin electrophoresis. Seventeen of 36 members of the family had hereditary elliptocytosis. The elliptocytosis trait was not linked to the ABO, Rh, or Duffy blood group systems. No associated red cell enzyme defect or hemoglobin abnormality was detected. Persons with elliptocytosis showed no difference in hemoglobin levels, but tended to have higher bilirubin values, and significantly higher reticulocyte counts (p .05) and lower haptoglobin levels (p .05). Of the 17 members of this family with morphologic evidence of hereditary elliptocytosis, at least nine (53 percent) had evidence of hemolysis as indicated by an elevated reticulocyte count associated with a decreased serum haptoglobin level. Splenectomy in three of the four patients corrected the hemolytic anemia.

* * *

Effect of Carbon Monoxide on Tissue Oxygen Supply

Arthur L. Sagone, Jr., M.D.; Thomas Lawrence; and Stanley P. Balcerzak, M.D., F.A.C.P., Columbus, Ohio

The purpose of this study was to determine if chronic exposure to low levels of carbon monoxide in man results in tissue hypoxia. The presence of hypoxia was assessed by measurement of erythrocytic adaptive mechanisms in nine men who smoked greater than one pack of cigarettes per day and compared to 18 non-smokers of similar age, sex, and race. The adaptive responses which were measured were oxygen-hemoglobin affinity (P50), red cell mass (RCM), and red cell 2,3 diphosphoglycerate (2,3 DPG), and adenosine triphosphate (ATP).

Results are tabulated below:

	RCM ml/m²	P50	2,3 DPG μm/gm Hb	ATP μm/gm Hb	COHb %
Controls (18)	1132	24.2	12.7	5.15	1.1
SD	±91	±1.2	±1.8	±.52	±.5
Smokers (9)	1321	23.1	12.7	4.51	6.2
SD	±116	±1.1	±2.1	±.53	±1.3
P value	<0.001	<0.05	NS	<0.05	<0.001

Hemoglobin and hematocrit values, and red cell counts also were significantly higher in the smokers.

These data suggest that chronic exposure to low levels of carbon monoxide results in tissue hypoxia probably as a result of decreased blood oxygen carrying capacity and increased oxygen-hemoglobin affinity. Adaptation to this hypoxia is

principally reflected in an increased RCM. This response in RCM may be to the level seen in polycythemia rubra vera as evidenced by a value of 1581 ml/m^2 in one smoker. Three months after cessation of smoking, however, this patient's RCM decreased to normal. No significant intraerythrocytic adaption occurred as shown by unaltered erythrocyte 2,3 DPG and decreased ATP levels.

This study suggests that chronic exposure to low levels of carbon monoxide may further embarrass tissue oxygen supply in patients with anemia, arteriosclerotic heart disease, chronic lung disease, and cerebral vascular disease in whom oxygen delivery to tissues is already marginal.

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Adaptation to Hypoxia in Patients with Chronic Obstructive Pulmonary Disease

Jerry T. Guy, M.D.; James Kazura; Philip A. Bromberg, M.D., F.A.C.P.; and Stanley P. Balcerzak, M.D., F.A.C.P., Columbus, Ohio

The interplay of the adaptive mechanisms to chronic hypoxia is poorly understood. This problem was studied in seven hypoxic patients with chronic obstructive pulmonary disease (COPD). Erythropoietic response was evaluated with ^{51}Cr red cell mass (RCM), plasma iron turnover (PIT), marrow stainable iron (Fe), and urinary erythropoietin (EP) levels. Intraerythrocytic adaptation was studied with blood-oxygen dissociation curves and red cell 2,3-diphosphoglycerate (DPG) values. Tissue oxygenation was estimated with cardiac index (CI), P_aO_2, and mixed venous (pulmonary artery) oxygen tension. Results are shown in the table below.

These findings indicate that some hypoxic patients with COPD do not display either an intraerythrocytic response or an erythropoietic response to their hypoxia. Patients 1 and 2 allowed venous oxygen tension (and mixed venous oxygen saturation) to become subnormal while erythrocyte DPG levels and blood oxygen affinity remained normal. Contrary to present concepts of regulation of erythropoiesis, low venous oxygen tension values in these patients did not stimulate increased EP levels and RCM did not increase. These studies suggest that the response of the erythron to hypoxia is not stereotyped and may be modified by the peculiarities of the disease state which is producing the hypoxia.

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Chemotherapy with Triple Alkylating Agents Plus Steroids in Patients with Untreated Multiple Myeloma

John B. Harley, M.D.; Ilhoon Kim, M.D.; and P. V. Thiagarajan, M.D., Morgantown, West Virginia

Thirteen untreated patients in whom the diagnosis of multiple myeloma was made were started on treatment with a combination of BCNU 100 mg/M^2 with Cytoxan® 300 mg/M^2 and Alkeran® 8 mg/M^2 orally plus prednisone 1.2 mg/K daily x 14 then reducing doses. Cyclic treatment was performed every six weeks. The regimen was well tolerable to all patients and no severe toxicity was encountered with the dosage modification guided by leucocyte and platelet count. All patients attained a good subjective response. Objective responses have been documented in patients to date. All patients seen at West Virginia Uni-

Table

Patient	Sex	P_aO_2 mm Hg	Ven. Oxygen Tension mm Hg	CI L/min/m^2	Diss. Curve Ven. Oxygen Tension	DPG μm/g Hb	RCM ml/kg	PIT mg/kg/day	EP	Fe	Art. pH
1	(M)	55	34	3.5	25.4	16.2	31.9	0.65	n*	+	7.41
2	(F)	60	33	—	25.1	17.7	21.5	—	n*	+	7.40
3	(M)	60	—	—	24.9	13.1	22.5	0.45	—	+	7.37
4	(F)	66	40	2.3	23.6	15.9	—	0.25	n*	+	7.38
5	(F)	40	29	3.6	25.0	14.3	39.0	0.62	—	+	7.36
6	(M)	55	—	—	24.7	15.7	37.3	0.61	—	—	7.38
7	(M)	49	35	3.1	26.2	16.6	54.2	0.52	—	+	7.39
Normal	(M)	90±	40	2.1—	23.0—	12.0—	30.0	0.18—		+	
	(F)	10		4.9	26.0	18.0	25.0	0.54			

* normal

versity Hospital since March 1970 have been entered on this protocol.

The percent of objective and subjective responders in this group of patients as compared to a previous study performed by A.L.G.B. shows an improved response rate.

Comparing the early deaths there have been no deaths encountered to date. This is in sharp contrast to our previous experience.

This study does demonstrate the safety and efficacy of this combination. Conclusions as to improved response or survival are implied.

The study area, West Virginia, was divided into nine regions: charts are available which show the year when alkylating agents became the accepted therapy in a majority of cases in the respective regions.

* * *

Multiple Myeloma: An Analysis of an "Unselected" Patient Population

John B. Harley, M.D., F.A.C.P.; and John M. Krall, Ph.D., Morgantown, West Virginia

The question, "Do alkylating agents significantly increase survival of multiple myeloma patients," is answered in the affirmative by analyzing survival data from 249 patients from the West Virginia Tumor Registry, 1960 to 1970.

The patient population was divided into three groups: those who were treated with alkylating agents, those who received no alkylating agents, and those with unknown treatment. The median survival of the group treated with alkylating agents (18 months) was significantly better ($P<.05$) than the median survival of the concurrent control group who received no alkylating agents (six months); it was also better than the median survival of the group with unknown treatment.

Analysis of the alkylating agent-treated group survivals for those patients treated at a primary hospital vs those patients treated at a referral hospital revealed no significant difference ($P>.05$).

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Hyperinflation of the Lungs in Coal Miners

William Keith C. Morgan, M.D.; Dean B. Burgess, M.D.; N. LeRoy Lapp, M.D., F.A.C.P.; and Anthony Seaton, M.D., Morgantown, West Virginia

The residual volume and total lung capacity of 1455 working Pennsylvania coal miners were determined as part of a larger epidemiological study. The age of the subjects varied between 18 and 65 years with a mean of 48.7 years. The total lung capacity of the subjects was determined from standard posteroanterior and lateral chest films while the forced vital capacity was determined by spirometry (O'Shea, Lapp, Russakoff, Reger, and Morgan 1970). The effect of increasing radiological category of simple coal workers' pneumoconiosis on lung volumes was investigated. It was shown that the residual volume increased with radiological category and that this occurred whether or not the miners had obstructive airways disease. The presence of obstruction had an additional effect over and above that due to coal dust alone, so that the largest increase in residual volume was found in miners who had both obstruction and radiological evidence of simple coal worker's pneumoconiosis.

* * *

Bioeffects of Certain Respirable Fibrous Dusts

Robert T. P. deTreville, M.D., F.A.C.P., Pittsburgh, Pennsylvania

After a brief review both of the Act and of current concepts of thresholds of safe exposure at work, data from epidemiologic investigations and experimental pathology studies will be presented concerning significance of ferruginous bodies of so-called "byssinosis bodies," and of bare fibers of various types found in adult human lungs at autopsy. Plans for additional research in certain areas will be cited. Every attempt will be made on the part of industry (labor and management) and government to expedite implementation of the provisions of the new Act, and it will be advisable for physicians in industrial communities who serve as consultants in the diagnosis of occupationally related respiratory conditions of all types to keep current and to be in a position to apply the latest and best information on environmental bioeffects in clinical practice.

* * *

A System for Coronary Care Evaluation

David E. Reed, M.D., (Associate); Robert R. Carpenter, M.D., F.A.C.P.; and Coralea N. Lapenas, Pittsburgh, Pennsylvania

The records of over 500 patients with a discharge diagnosis of myocardial infarction (MI) were reviewed in nine community hospitals including urban and rural, teaching and nonteaching, and allopathic and osteopathic in Western Pennsylvania. Sixty-one items were included on a standard abstract form to reflect patient identification, history, physical findings, laboratory data including electrocardiogram (EKG), therapeutic

measures, complications, and outcome. The records were reviewed by trained nonphysician personnel. EKG interpretations were done by physicians. Only cases in which the diagnosis was supported by EKG, enzyme, or autopsy evidence (85 percent of cases) were included in the data analysis. Comparisons of the data from individual hospitals show significant variations in both patient care practices and outcome. Use of certain treatment (lidocaine and atropine or pacemakers) was apparently correlated with higher survival rates. Mortality rates range from 21 percent to 41 percent.

As innovative effective methods are developed to improve health care, new methods for evaluation of their use which are acceptable to physicians, effective, and economical are needed. The record review described meets these criteria. Using already available records, it locates weaknesses in coronary care associated with high mortality rates and can be used to evaluate the effectiveness of intervention to correct these deficiencies.

* * *

A Profile for Long-Term Survival (10 to 20 years) Following Myocardial Infarction

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Thirty-seven living patients, who have survived 10 to 20 years postmyocardial infarction (PMI), are reviewed in this study. These patients include 14 surviving 15 to 20 years, and 23 patients surviving 10 to 15 years postmyocardial infarction.

Review of the cases reveals features the group to have in common: (1) The presence of longevity in one or both parents or grandparents. (2) The age of onset of the MI. Significant was the occurrence of MI frequency in the early 50s, especially in the group surviving 15 to 20 years. The majority were in the normotensive range, especially in the 15 to 20 year survivals. (3) Abstention from smoking in the majority of patients. The few smokers could be classified as light smokers. (4) In the patients who have survived 15 to 20 years, occupations have been those which did not require hard physical effort. (5) Only one black patient was found in this entire series. (6) Angina is slight or absent in this group. (7) Many of the patients have high uric acid levels and variable lipid profiles.

Location of infarct and severity of infarct did not appear to play a dominant role. Reinfarction was encountered in a moderate number of cases.

A profile for PMI long-term survivals includes the white, normotensive, non- or light smoker, whose occupation consists of nonstrenuous work, whose onset of MI is approximately at age of 50 years and who possesses a strong genetic background for longevity.

* * *

Survival of Patients with Potentially Fatal Arrhythmias: Long Term Study From A Large Cardiac Monitoring Unit

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Of the 1450 patients admitted to the 20-bed cardiac monitoring unit, of The Jewish Hospital, Cincinnati, Ohio, during the years 1967 and 1968, twenty-three patients were discharged alive after having been successfully resuscitated from ventricular tachycardia, ventricular fibrillation, and cardiac arrest. The longest follow-up is now four years and nine months. As of August 1971, out of 23 patients, 12 patients are dead, ten are alive, and there is no follow-up on one patient. The average age of these 12 patients who have died is 63.8 years, and the duration of their survival after the episode of arrhythmia ranges from six weeks, to two years and seven months, with an average survival of one year. Three of these patients had had cardiac arrest, six had ventricular fibrillation, and three had ventricular tachycardia. Of the ten patients who are alive, two had had cardiac arrest, seven had ventricular fibrillation and one had ventricular tachycardia. Their average age is 62 years, and survival ranges from three years and five months, to four years and nine months, with a mean of four years and one month. Out of 23 patients, acute myocardial infarction was the cause of arrhythmia in 20 patients. In the other three patients, all of whom had ventricular fibrillation, the known etiological factor included hypokalemia and digitalis intoxication in one instance each.

Of the 23 patients, these arrhythmias occurred during the first five days in 18 patients, but in five patients, they occurred as late as the 6th, 10th, 13th, 15th, and 17th day. There was no correlation between the day of occurrence of arrhythmias and the survival. In this small group of patients, the type of arrhythmia made no apparent difference in the duration of survival.

Of the ten patients who are alive, all of them are mentally competent and are doing well.

This study documents the follow-up of patients who are salvaged from potentially fatal arrhythmias and suggests a particular value of a large cardiac monitoring unit which admits patients in an unrestricted fashion, and permits patients to remain an extended period of time.

Rhinoplasty

Its Development and Present Day Usages

Anthony B. Sokol, M.D., and Ronald B. Berggren, M.D.

History

RHINOPLASTIC OPERATIONS originated in 2500 to 600 BC (Period 1) as chronicled in early Indian literature by Sushruta Samhita.[1] Simultaneously, Egyptian hieroglyphics gave accounts of nasal reconstruction. Rhinoplasty was a courageous undertaking at that time for both patient and surgeon. The patient, usually a prisoner whose nose had been removed as punishment for a crime, was operated upon without anesthesia by a pottery maker who used a midline forehead flap to reconstruct the nose. The flap (Fig. 1), based upon the supraorbital and supratrochlear vessels was kept in place by cloth strips.[2] This method was still practiced in the 19th century as described by Shah and Pinto.[3,4]

In Period 2, the Brancas and Gaspare Tagliacozzi, Italian surgeons of the 15th and 16th centuries, had not heard of the Indian method of nasal reconstruction and developed the arm flap rhinoplasty (Fig. 2). This became known as the Italian method of nasal reconstruction. It was first reported by Tagliacozzi in his landmark surgical text, *De Chirugica Plastica.*

Traveling European surgeons and military men became acquainted with the Indian method during the early 19th century (Period 3) and brought a description of it back home with them. It was practiced subsequently by men such as Carpue[2] and Delpech.[5] Reconstruction of nasal parts by adjacent skin flaps with reported by Bünger who also used full-thickness skin grafts for nasal resurfacing.[1] Carl Ferdinand Graefe published the first book devoted primarily to the rhinoplasty technic in 1818 describing the use of the Indian and Italian reconstructive measures.[7]

Rhinoplastic surgeons became aware of the need of cartilaginous and bony support for total nasal reconstruction during the 18th century. Later they realized that internal lining was necessary to prevent shrinkage. Johann Friederick Diffenbach, to whom some refer as the father of rhinoplasty, not only mastered the previous technics of reconstructive rhinoplasty, but also conceived of esthetic rhinoplasty.

Two historical developments in the history of rhinoplasty occurred at the beginning of the 20th century; septal surgery was developed by Killian and Freer, and the completely internal rhinoplasty was done by Roe in New York and Joseph in Germany.[8] Before World War I, Doctor

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Fig. 1. Illustration of early Indian rhinoplasty.

Jacques Joseph in Germany perfected the modern cosmetic rhinoplastic operation and taught these technics to many contemporary rhinoplastic surgeons including Gustave Aufricht and Joseph Safian.

Gillies, answering the need for nasal reconstruction resulting from war injuries, developed multiple technics including the tubed pedicle flap. Converse,[14] unhappy with the cosmetic distortion of facial anatomy by the Indian method and the time-consuming delay of other pedicle flaps, developed a scalping flap.

Esthetic Rhinoplasty

Anatomic Considerations.— The nose is composed of four structural parts (Fig. 3). The paired alar cartilages and the anterior portion of the septal cartilage comprise the tip. The pyramids are composed of the paired nasal bones and upper lateral cartilages. The nasal bones and the septal cartilage contribute to the dorsal line. The septum is composed of the vomer, perpendicular plate of the ethmoid, and septal cartilage lying in the vomerine groove. All four parts must be evaluated by the surgeon planning a rhinoplasty. A nose cannot be corrected for one abnormality without simultaneous adjustment of the other three parts to compliment the altered form.

The indications for rhinoplasty are a combination of the patient's desire and the surgeon's experience with a multitude of technics. The motivation and the expectations of the patient must be considered before accepting the patient for surgery. The physician's evaluation is discussed fully with the patient and the surgical goals of the patient and surgeon are coordinated and viewed realistically.

The many technics of rhinoplasty cannot be discussed in detail. However, the four basic steps will be described to demonstrate the conceptual design of the procedure.

The Procedure.— The operation is performed either under local or general anesthesia with epinephrine infiltrated locally for its vasoconstrictive effects.

The nasal tip is modified by resection of the alar cartilages and the caudal border of the septum (Fig. 4). The transverse dimension is narrowed by resection of the superior border of the alar cartilages and the domes of these structures. The length or protrusion of the tip is determined by the position of the caudal border and angle of the septal cartilage as related to the anterior nasal spine. The protruding tip is corrected by a resection of the septum, and the short tip is lengthened by an implant of septal cartilage or other material to correct the relationship of septal cartilage with the anterior nasal spine (Fig. 5).

The dorsal hump, an abnormal projection of

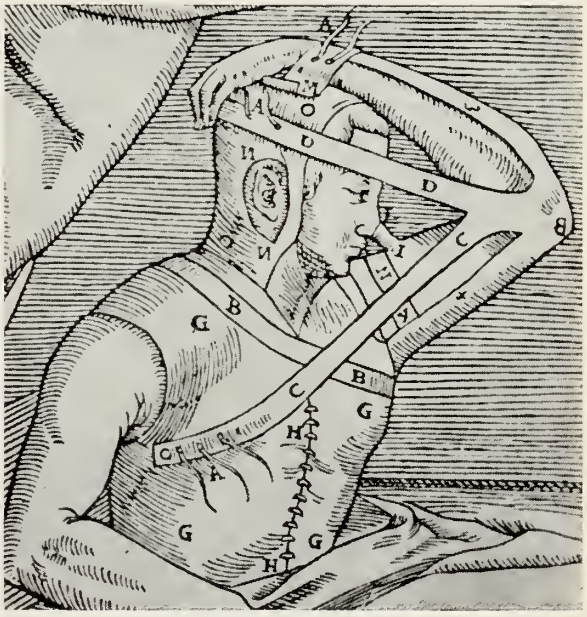


Fig. 2. Tagliocozzi's Italian arm flap.

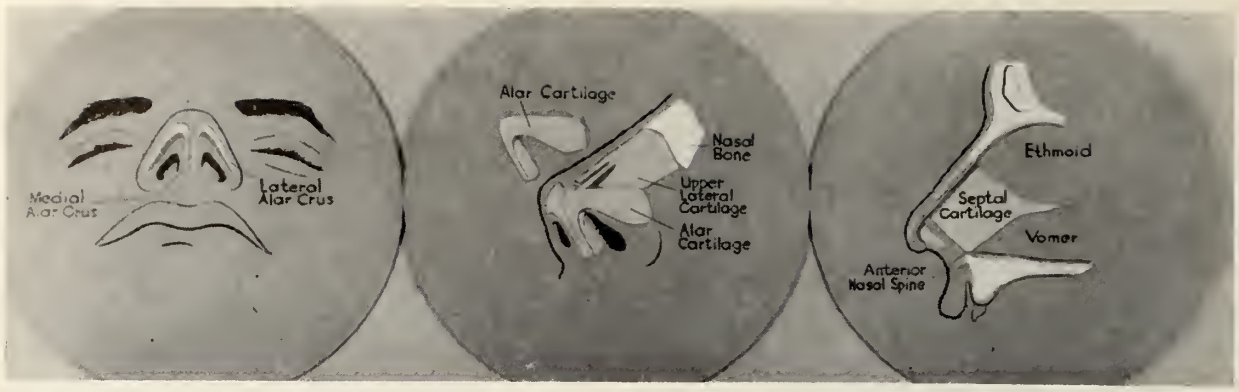


Fig. 3. Anatomy of nasal skeleton.



Fig. 4. Rhinoplastic step 1. Reduction of nasal tip, width, and height. Narrowing of angle described between medial and lateral alar cartilage crura and reduction of height accomplished by resection of superior margins of alar cartilage crura.

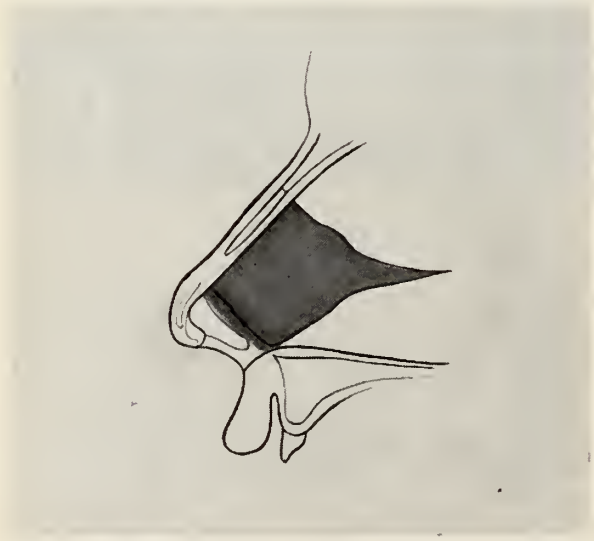


Fig. 5. Rhinoplastic step 2. Reduction of nasal tip length. Nose length is described by relation of septal cartilage to anterior nasal spine. Protruding nose is modified by resection of overhanging nasal septum.

bone and cartilage, is removed with saw, chisel, or forceps (Fig. 6).

The width of the nasal pyramid, a dimension determined by the bony pyramids and lateral cartilages, is narrowed by lateral osteotomies, which are performed intranasally or through the labial sulcus. The nasal bones are fractured to achieve the desired narrowing (Fig. 6).

Any septal deviation giving an external deformity or nasal obstruction must be resected without removing the important supporting portions of this structure. This resection is carried out beneath the mucosa so that only the cartilage is removed and the septum remains intact (Figs. 7 and 8).

The operation is completed by suturing the intranasal incisions and packing the nostrils with a lubricated pack to maintain mucosal apposition. An external splint is applied for seven days to maintain the new position of the bony pyramid.

Reconstructive Rhinoplasty

Nasal reconstruction is performed today for total losses of nasal tissue due to trauma, disease, or congenital anomalies. Reconstructive elements are taken from local or distal donor sites. Usually these elements are composed of skin and subcutaneous tissue with an intranasal lining of skin. Support is given by the use of free autogenous bone grafts or alloplastic material.

Partial Nasal Reconstruction.— Partial thickness losses of skin alone are repaired with nonhairbearing skin grafts. They are sutured in place with a tie over bolster stent dressing. At four days the stent is removed, and the graft is inspected. Sutures are removed in five to seven days. A good cosmetic result can be expected if careful consideration is given to the site of donor skin.

Selected examples from treatises that have been written on nasal reconstructive procedures will be reviewed in this paper as illustrations of the many ingenious procedures conceived.[1,9,10] Many local flaps have been conceived and used



Fig. 6. Reduction of dorsal hump and base. Hump is modified by straightening dorsal line of nasal septum and bones. Base of nose is narrowed by infracturing paired nasal bones and lateral cartilages.



Fig. 7. Septoplasty. Submucous resection is performed by removing nonsupport areas of obstructing and deviated nasal septum.

for partial nasal reconstruction. The case presented in Figures 9 and 10 will serve as an example of one type of partial nasal reconstruction.

A 50-year-old man lost the full thickness of his left alar cartilage. A nasolabial flap was raised and implanted into the defect. The inferior margin was turned in to provide a lining. In three weeks the flap was divided, and the donor site was revised to leave the scar well situated in the nosolabial fold (Fig. 11).

A comparative summary of the advantages and disadvantages of the various methods of partial nasal reconstruction is shown in Table I.

Total Nasal Reconstruction.— Total reconstruction of the nose requires more extensive planning and design. A total scalping flap was used in the last case (Fig. 12) for it allows excellent nasal reconstruction with only a minimal amount of visible cosmetic deformity.[14]

This 43-year-old woman had a wide resection of her nose for advanced basal cell carcinoma. The resection left internal nasal support, with preservation of the septum and the superior portion of the nasal bones. The margins were declared free of tumor on examination by the pathologist.

A scalping flap was raised based upon the contralateral, superficial, temporal, and posterior auricular vessels. The ipsilateral forehead skin and subcutaneous tissue were used to fashion the new nose. The frontalis muscle was left in place to allow the forehead to remain expressive. The forehead defect was covered with a thick split-thickness skin graft. The patient's flap was divided and replaced after three weeks during which time the new nose had established a blood supply from the recipient area. The grafted area has continued to become paler and less obvious.

Summary

Rhinoplasty is an operation for rebuilding or reshaping the nose. Reconstructive rhinoplasties were performed by ancient Indians and Egyptians as early as 2500 BC and the technic was published in an ancient Indian surgical text, *Sushruta Samhita*. In the 15th and 16th centuries, new methods of nasal reconstruction were described in *De Chirugica Plastica,* a surgical text written by an Italian surgeon, Gaspare Tagliacozzi. Traveling European surgeons of the 19th century brought the Indian technic to Europe. These were combined with the Italian method and improved upon by Carpue, Delpech, and Graefe. Further con-



FIG. 8. Protruding tip and dorsal hump (left). Postoperative result (right) after resection of excess dorsal bone and cartilage. Note acceptable dorsal line. Satisfactory nasal tilt to tip achieved by resecting protruding nasal septum.



FIG. 9. Airway obstruction secondary to deviated nasal septum (left). Note broad base and irregular nasal tip. Postoperative result (right) shown after rhinoplasty and submucous resection of obstructing nonessential septal cartilage. Note acceptable straightened dorsal line and symmetry of nasal tip.



FIG. 10. Dorsal hump in post-traumatic nose (left). Postoperative result (right) after resection of septal cartilage and revision of alar cartilage crura. Note acceptable dorsal line.

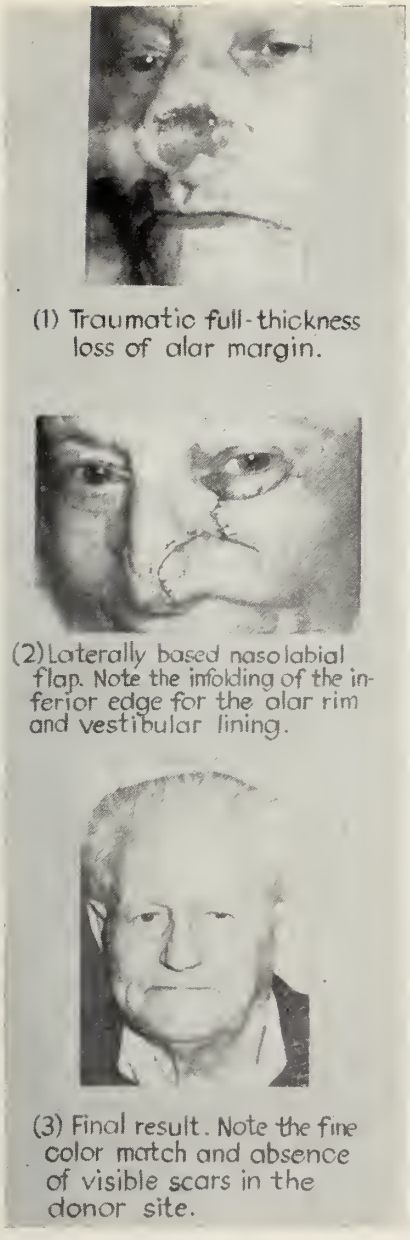


Fig. 11. Partial nasal reconstruction.

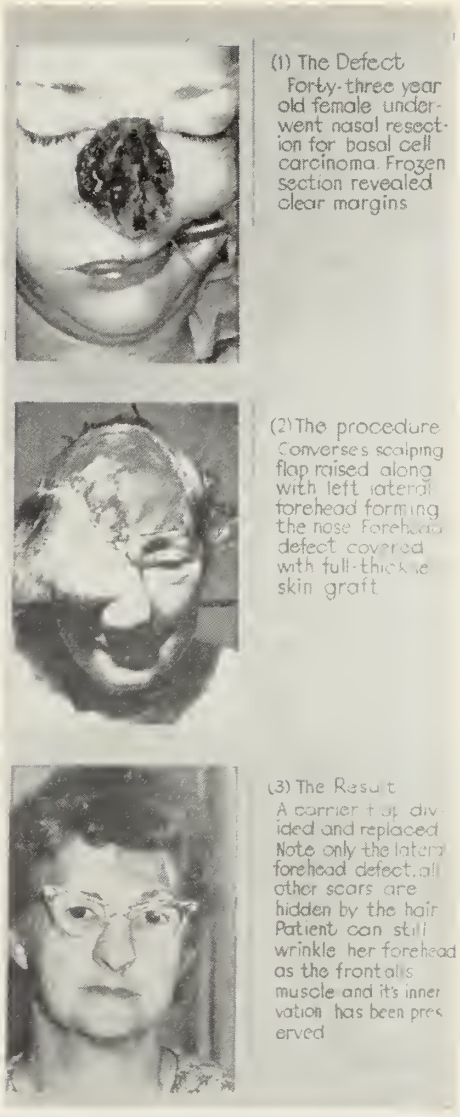


Fig. 12. Total nasal reconstruction.

Table 1. Varieties of Alar Cartilage Reconstruction

Flaps
1. Schmids—frontotemporal flap
2. Auricular composite graft
3. Nasolabial flap
4. Cervical flap
Local flap's advantages
1. Good color match
2. Available tissue with good blood supply
3. Brief period of immobilization
4. Scars usually not noticeable
Auricular composite graft's advantages
1. Good color match
2. One procedure required
3. Excellent cosmetic results for defects less than 2 cm.

tributions were made by Gillies in the 20th century.

The esthetic rhinoplasty for remodeling the nose was conceived by Diffenbach in the 19th century. Early in the 20th century, Killian and Freer developed nasal septal surgery. Roe, in New York, and Joseph, of Germany, refined the technic and it has been carried out in much the same fashion since that time.

The esthetic operation is divided into four parts. The first is the modification of the nasal tip by trimming the alar cartilages. Part two is shaping the caudal border of the septum and the angle it makes with its dorsum. Part three is the removal of the dorsal hump with lateral osteotomies to move the bony nasal pyramid toward the midline. The fourth part, not always

included in the operation, is submucous resection and/or repositioning of the septum.

Reconstructive rhinoplasties may be partial or total. The method for partial reconstruction of the nose depends upon the degree of the defect. Small defects with adequate tissue at the base are repaired with free-skin grafts. When full-thickness losses have occurred, adjacent pedicle flaps are necessary for a satisfactory result.

Total reconstruction of the nose requires the establishment of three basic constituents of the nasal structure: cover, support, and lining. Cover is usually provided with a pedicle flap from some area of the face. If the skeleton of the nose is damaged, the support may be obtained by use of a free-bone graft. Lining is necessary to prevent contracture of the new nose. This lining is made of free-skin grafts or a secondary pedicle flap. Each of these constituents must be provided to acquire a satisfactory appearance and function of the new nose.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

This two-year-old boy enters the emergency room with marked swelling of his left upper eyelid. There is no history of trauma, but he has had an upper respiratory infection for the past several days with nasal drainage and a temperature of 101 F (Fig. 1).

What steps should be taken in diagnosis and treatment?

(See p. 566 of this issue for further information and discussion.)



Fig. 1. Appearance of patient on admission.

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Submitted January 18, 1972.

Maternal Deaths Involving Sickle Cell Anemia*

By the OSMA Committee on Maternal Health

With Comment of Consulting Hematologist

AS THIS ARTICLE goes to press, there is considerable discussion in both lay and professional circles concerning sickle cell disease. Currently, several bills are pending in the Ohio Legislature[1] requiring testing for the disease among children and premarital persons. In a most recent article, Fort, et al, studied patients with sickle cell hemoglobinopathies admitted pregnant, over a ten-year period, then concluded that the pregnancy outcome *failed* to justify the maternal risk involved.

Scanning 1462 cases in the Ohio Maternal Mortality Study (1955-1970), we found six patients who had a record of sickle cell involvement. Two of these (sickle trait) are eliminated (one with virus pneumonia and one dying of sepsis).

Herewith the Committee presents the remaining four case reports related to sickle cell disease; three patients died postpartum, and one patient died undelivered.

Case No. 837

This was a 27-year-old, Negro primigravida who died about one hour postpartum. In her second month, she registered with her physician; last menstrual period was June 10. Both the family and past histories were negative. Her blood type was A-positive, results of serology tests were negative, and hemoglobin level was 12.7 gm per 100 ml. The pregnancy progressed without complication until the eighth month, when she developed 2-plus proteinuria, without hypertension or edema. On February 13 (35 weeks), she was admitted in "false labor," with blood pressure of 140/90 mm Hg. Under mild sedation the pressure became normal, but later soared to 176/80 mm Hg as the "labor" stopped. Uric acid and blood urea nitrogen determinations were normal; the patient became irritable, demanded to leave, and did. Four days later, she returned in early labor with blood pressure of 150/100 mm Hg, irritable, "flighty," crying, and membranes spontaneously ruptured. Labor was irregular. An unsuccessful attempt was made to stimulate contractions with oxytocin. Parenteral fluids were started. The patient became haughty, restless, and she developed chest pain. The next day (February 18) she seemed to be deteriorating mentally. A second attempt to stimulate labor was unsuccessful also; the patient became restless, thrashed about, and finally developed left hemiparesis of the face and arm (only). Faced with potential infection (ruptured membranes) and failure to induce labor, consultants entertained advice for a cesarean section. A preliminary blood count revealed 6.4 gm per 100 ml hemoglobin, 2 million erythrocytes, and an incidental "smear" showed sickle cells with 5 normoblasts per 100 white blood cells. Proteinuria (with granular casts) and positive urobilogen in 1/200 dilution led to a test for icterus index, which proved to be 26.1 units. The internist, with a diagnosis of *sickle cell crisis* now advised slow transfusion, and vaginal delivery with minimal anesthesia. Labor progressed, the fetal heart beat disappeared, and after three hours, a stillborn 2270 gm (5-lb) fetus was delivered. The third stage of labor was uneventful, but dyspnea developed with mild convulsions and the patient died within the hour.

Cause of Death (Autopsy): Sickle cell anemia; petechial hemorrhages of heart, stomach, pancreas, and bladder; verrucous endocarditis/aortic valve; infarcts of kidneys and spleen; pulmonary edema.

Comment

The Committee studied this case at great length with considerable discussion about negative family history and past history. This episode of sickle cell crisis *apparently* precipitated during pregnancy and was discovered incidentally during a "preoperative" hemogram. By a *narrow* margin, members voted this a *nonmaternal* death.

Case No. 1210

This was a 22-year-old, Negro, para II, who died four days postpartum. As a "high risk" OB patient (cardiac disease and previous sicklemia, 14 years), she registered in her fourth month in a clinic and made six prenatal visits; the last menstrual period was December 25. Her previous pregnancy was delivered, after abruptio

*A continuous statewide Maternal Mortality Study is being conducted by the Committee on Maternal Health of the Ohio State Medical Association in cooperation with the Ohio Department of Health and representatives of the various County Medical Societies. Summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published here from time to time, interspersed with statistical summaries.

placentae at 37 weeks, by cesarean section with a "stillborn" fetus; specific details were not recorded, except for pyelonephritis after delivery. She had been a regular patient receiving care from both the medical and hematologic clinics, having been treated for congestive failure and hemolytic crisis. Her last admission (30th week) was July 18, because of dyspnea, pain in abdomen and joints, and moderate icteric sclera. Laboratory studies revealed hemoglobin level 5.4 gm per 100 ml, hematocrit reading 14 percent and reticulocytes 29.4 percent. Treatment included digitalization for impending cardiac failure, and constant central venous pressure monitoring. After transfusion with three units of packed cells, the patient seemed to improve, but her condition deteriorated on July 28. Seven more units of packed cells were administered. The liver was enlarged (10 cm below the costal margin). On August 8, labor commenced with pain "over the uterine scar." A repeat cesarean section was performed, with tubal ligation, all uneventfully. The premature infant was alive; three units of whole blood were administered to the patient. Sepsis developed the second postoperative day, with positive blood cultures revealing staphylococcus; methicillin was administered. Her course was clinically "downhill" as she developed cerebrovascular thrombosis with infarction. Decompression was recommended by neurosurgeons, but refused by the family. Likewise, an autopsy was refused after the patient died on August 8.

Cause of Death (Certificate): Shock, cerebral hemorrhage; intra-abdominal hemorrhage; sickle cell disease; staphylococcic septicemia; congestive heart failure, cerebrovascular hemorrhage, thrombosis.

Comment

Members were impressed with the thoroughness with which records, diagnosis, and management were executed. Quite obviously the patient received ideal care and died in spite of all measures and therapy. The Committee voted this a nonpreventable maternal death.

Case No. 1345

This patient was a 25-year-old, Negro, para III, who died eight days postpartum. Two previous term pregnancies (1961 and 1966) were delivered without complication! *Not* revealed to her physician was her care at a clinic in 1964 when a hemoglobin electrophoresis revealed a sickle anemia with hemoglobin C 49 percent and hemoglobin S 50 percent. She registered with the physician in the *fifth* month (last menstrual period on April 7) making only three visits. (She was actually a "high risk patient," obesity and sickle cell disease.) After one visit, the patient was admitted at 37 weeks (December 22) with dyspnea and abdominal cramping, discharged in two hours, and readmitted January 15 (2:05 AM) with the same complaints plus severe chest pains and a term-size uterine pregnancy, in early labor. Results of laboratory tests were hemoglobin level 9.1 gm per 100 ml, white blood cell count 24 percent, hematocrit reading 26 percent, large number of target cells, and few nucleated erythrocytes. The urine was normal. Labor ensued spontaneously at 8:05 PM on January 15, and the patient was delivered spontaneously at 4:16 AM on January 16 of a living 3856 gm (8-lb 8-oz) baby, saddle-block anesthesia. The placenta was delivered manually with blood loss of 250 cc; there were no lacerations. Cramping pains in the legs and abdomen developed late on January 17, and on January 19, protein electropharesis revealed absent normal adult levels of hemoglobin, C 56.5 percent and S 43.5 percent, with a positive sickle cell smear. *Chest* and *abdominal pain* remained in spite of analgesic and narcotic medication.

On January 22, dyspnea increased with severe chest pains, with a negative report from chest x-ray film. A friction rub developed January 23; digitoxin and tetracycline were administered regularly. The patient became confused on January 24, blood pressure was 100/70 mm Hg with pulse rate of 130 per minute, and she died January 24. Autopsy was permitted.

Cause of Death (Autopsy): Sickle cell hemoglobin C disease; thrombosis of pelvic veins; pulmonary embolism, multiple, bilateral.

Comment

With considerable interest, Committee members studied facts presented in this case. The patient withholding vital information from her last physician, and her failure to fulfill sufficient visits for adequate prenatal care, were fully considered and discussed. Finally, the Committee (by narrow margin) voted this a nonpreventable maternal death.

Case No. 1489

This was a 20-year-old, Negro, gravida II, para I, who died undelivered in her 32nd week of pregnancy. Two siblings have sickle cell anemia. Her past history included *numerous* sickle cell crises and *multiple* transfusions. She was known to have homozygous hemoglobin S disease. Details of her previous (term) pregnancy were not recorded. She was a "high risk patient" (sicklemia and low socioeconomic status). Last menstrual period was April 15 (?) and the patient was readmitted for the *11th time* on November 24 (7½ months); her previous admission of *two months'* duration was for treatment of pyarthrosis of knees and elbows, a urinary tract infection, and a breast abscess (chloramphenicol). On this admission, the patient entered the labor room with mild uterine contractions at three-to-four minute intervals, vital signs were normal except for a rapid pulse, fetal heart beats 100 to 156 per minute but regular. Laboratory studies reported: hemoglobin level 9.3 gm per 100 ml, white blood cell count (WBC) 19,750 per cu mm (80 percent neutrophils), and 110 nucleated erythrocytes per 100 WBC. Parenteral fluids with (added) chloramphericol were given. The patient complained bitterly of pain in the abdomen, the lower back, and the knee. Subsequent medication included Vistaril, morphine, and codeine, before 11:45 PM. Labor continued, with more regularity and heart sounds dropped to 84 per minute at 2:10 AM, November 25. She voided 150 cc of dark urine and received Seconal 3 gr and morphine sulphate 1/6 gr intramuscularly. By 3:15 PM, November 25, the patient became clammy, produced profuse diaphoresis, and was unresponsive; the pupils were constricted and unreactive. As the blood pressure dropped, cyanosis developed, and the peripheral pulse disappeared. After administration of nalorphine at 4:00 AM, the vital signs improved slightly; the urinary output was 150 cc with intake of 950 cc. The patient was seen by a medical consultant at 8:00 AM, November 25, and his impression was: "hypertension and oliguria, consider dehydration and R/O septicemia." Therapy thereafter consisted of lanatoside C 4 mg, digoxin 0.5 mg, mannitol 12.5 gm, and a central venous pressure catheter was inserted; it registered 13 cm H_2O. Urine and blood cultures produced no growth. Uterine contractions continued as the cervix reached a maximum dilatation of 4 cm. By 6:00 PM the patient became extremely cyanotic, pursued a downhill clinical course, and she died undelivered 26 hours after admission, in spite of all therapeutic measures.

Cause of Death (Autopsy): Sickle cell disease; multiple splenic infarcts; pulmonary edema; pulmonary thrombosis; congestive hepatomegaly; pregnancy uterine, circa eight months (2340 grams); diverticular hypertrophy; chronic pyelonephritis; and terminal pancreatitis.

Comment

The Committee studied available facts in this case with deep interest, noting the good quality of the records. Members, in deliberation, felt that although the last course of treatment seemed adequate, the patient should not have entered the second pregnancy. The case was voted a nonpreventable maternal death, by a narrow margin.

Comment of Consultant

The following comments of a consultant, who is a hematologist, was furnished at the request of the Committee:

"The four cases reviewed concern a problem, most likely long existent—but not necessarily, clinically appreciated, and well recognized. The problem's actual—and potential—importance may be indicated by an excerpt from a recent text of hematology: 'The severity of sickle cell disease may be accentuated during pregnancy and obstetrical complications are frequent, with a high risk of mortality to mother and child.'

"Case 837 is a 27-year-old primipara presenting with a negative past history; a pregnancy progressing without complication until the eighth month; and who then develops proteinuria, hypertension, false labor, irritability, emotional instability, restlessness, chest pain, left hemiparesis, anemia with findings positive for hemolytic activity, mental deterioration, with dyspnea, and mild convulsions leading to death within an hour postpartum. All are strongly consistent with a changing hematovascular situation of hypoxia leading to a catastrophic climax. The autopsy findings are those of an acute crisis of a sickle hemoglobinopathy. In this situation, interpretation of a death, other than *maternal,* is not consistent with the progressive clinical course and with the known facts.

"The question of nonpreventable natural death in the parturient individual with sickle hemoglobinopathy is a complex, and obviously multifaceted, problem requiring advice and assistance from different disciplines. However, from the medical standpoint, early detection is essential.

" 'Never assume that a Negro woman has *no* hemoglobinopathy until it is proved that she is free from it.' Cases 837 and 1345 well illustrate this need, while medical literature includes references to diagnoses not being established until the third and fourth decade. Negative patient and family histories are *not conclusive.*

"Once *alerted* to the presence of a hemoglobinopathy, the attending physician must be *acquainted* with the symptoms or signs that indicate activation of the hemolytic and/or thrombotic process. As in case 1345, the patient was admitted with dyspnea and abdominal cramping; three weeks later, she was readmitted with the same complaints plus severe chest pains. This would suggest that the sickle crisis process had initiated over three weeks prior to delivery of a viable infant, and that, possibly, the earlier or more aggressive awareness should have been considered before the irreversible state occurred.

"In case 1489, the observation is recorded: 'the patient should not have entered the second pregnancy,' yet the conclusion of *nonpreventable* maternal death was noted. Perhaps resolution of this particular dichotomy can occur only after more diligent examination of the problem of hemoglobinopathy and pregnancy is undertaken, this resulting in an aggressive utilization of available concepts."

Generic and Trade Names of Drugs

Hydroxyzine pamoate—Vistaril (Pfizer Laboratories)
Secobarbital—Seconal (Eli Lilly and Co.)

References

1. Ohio State Medical Association Legislative Bulletin 37 (Mar 10, 1972): Three Sickle Cell Disease Bills Referred to House Subcommittee: H.B. 944 (Thompson), H.B. 1004 (James), and H.B. 1024 (James).
2. Fort AT, et al: Counseling the patient with sickle cell disease about reproduction: Pregnancy outcome does not justify the maternal risk! *Am J Obstet Gynec* **111**:324-327, 1971.

THE SICKLE-CELL AND ALTITUDE. — High altitude seemed to be responsible for seven recent cases of sickling crisis. People with sickle-cell trait are at a risk if they fly in unpressurized aircraft, which are used for many local air services. Those with sickle-cell hemoglobin C disease should avoid air travel even in pressurized aircraft. Possibly as a result of "autosplenectomy," patients with sickle-cell anemia seem to be able to fly in pressurized aircraft with little risk. All passengers and aircrew who might have some form of sickle-cell disease should be screened before flight. — R. L. Green, M.B., Middlesex; R. G. Huntsman, M.D., London; and G. R. Serjeant, M.D., Cambridge: *British Medical Journal*, 4:593-595, Dec. 4, 1971.

Discussion of E.N.T. Case of the Month

(continued from p. 562)

When a patient presents with edema of the upper lid, infection of the nose and paranasal sinuses must be suspected as well as orbital disease.

The first step should be to elevate the patient's lid to see if there is any involvement of the orbital structures. In this patient, the sclera was not injected, there was no conjunctival edema, and he had a full range of ocular movement, indicating no serious involvement of the orbit. Next, examination of the nose should be done. This patient had marked inflammation of the mucosa on the left with copious mucopurulent drainage.

Radiographs of his paranasal sinuses showed clouding of the left ethmoid air cells (Fig. 2).

The diagnosis in this case was acute ethmoiditis with a periorbital abscess causing the secondary lid edema.



Fig. 2. Radiographs revealed clouding of left ethmoid air cells.



Fig. 3. Ethmoid air cells are in close approximation to contents of the orbit. Note thin bone separating these structures.

Infection of the ethmoid labyrinth can easily extend through the thin bone of the medial orbital wall forming a periorbital abscess (Fig. 3). Patients with this problem will usually present with swelling of the upper lid and nasal symtoms. When this diagnosis is made, therapy should be started immediately to prevent the intraorbital or intracranial spread of the infection. Most patients will respond to local nasal vasoconstrictors and antibiotic therapy, however, in some instances localized pus may form and must be drained through an external incision.

RESPIRATORY PATTERN and arterial blood gas tensions were assessed in patients with acute cerebrovascular accidents. Hyperventilation, low P_{CO_2}, and high arterial pH were associated with a poor prognosis, whereas patients with normal respiratory pattern and blood gas tensions survived. Periodic and Cheyne-Stokes breathing carried an intermediate prognosis. — M. W. Rout, M.B., D. J. Lane, D.M., and L. Wollner, M.B., Oxford, *British Medical Journal,* 3:7-9, July 3, 1971.

Professional Activities



Proceedings of The Council

Meeting of April 15, 16, 1972

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, April 15, 16, 1972 in the OSMA headquarters office, 17 South High Street, Columbus. Those present on Saturday, April 15, were: All members of the Council; Mr. James E. Pohlman, Columbus, legal counsel; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Dr. R. L. Meiling, Columbus, chairman of the Ohio delegation to the AMA; Dr. John W. Cashman, Columbus, Ohio Director of Health; Mr. William J. Lee, Columbus, Administrator, Ohio Medical Board; David A. Kindig, M.D., Rockville, Maryland, National Health Service Corps, present by invitation; Messrs. Page, Edgar, Gillen, Campbell, Rader, Moore and Mrs. Wisse of the OSMA staff.

Those present on Sunday, April 16, were the following: All members of the Council; Mr. Pohlman; Dr. Budd; Mr. M. Jerry Ketchum and Mr. Homer Harrison, representing Ohio Medical Indemnity, Inc., present by invitation; Dr. William J. Lewis, Dayton and Dr. Paul A. Jones, Zanesville, representing the Ohio Medical Political Action Committee, present by invitation; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Moore and Mrs. Wisse of the executive staff.

Minutes Approved

Minutes of the meeting of the Council held February 12, 13, 1972 **were approved** by official action.

Councilor Reports

The Councilors reported on activities in their respective districts.

Liaison with Medical Board

The Council voted to establish a liaison committee with the Ohio State Medical Board. The President appointed Dr. Frederick T. Merchant, Marion, to this position and the appointment **was approved** by the Council.

Dr. Press Congratulated

The Council officially congratulated Dr. Sanford Press, Steubenville, Councilor of the Seventh District, for his appointment by the Governor to the Ohio State Medical Board for a term of seven years, effective March 13, 1972.

President's Letter to Hospital Association Endorsed

The Council received and endorsed President Robechek's letter of March 8, 1972 to Mr. Stephen M. Morris, President, American Hospital Association, Chicago, concerning an article by Mr. Morris in *Medical World News* of February 25, 1972.

East Columbus Citizens' Organization

The Council then considered endorsement of a project application for health personnel which had been forwarded by the ECCO Family Health

Center to the National Health Service Corps on March 3, 1972. The application had the previous endorsement of the Columbus Academy of Medicine.

David A. Kindig, M.D., of the Professional Service Division, National Health Service Corps, Rockville, Maryland, addressed the Council concerning the Emergency Health Personnel Act of 1970 (91st Congress), which sets up the system for use of commissioned officers of the Public Health Service to improve the delivery of health services to persons living in communities and areas of the United States where health personnel and services are inadequate.

The Council **approved** the endorsement of the project application and adopted guidelines which preclude consideration of such requests until they are approved by the appropriate county medical society and until the Council has been so informed of this approval in writing by the county medical society.

Welfare Invoices

As a result of a communication dated April 1, 1972 from the Ohio Department of Public Welfare, the Council voted to reaffirm its previous position against the mandatory use of specific forms and coding of welfare invoices.

President's Address Approved

Dr. Robechek reviewed excerpts from his President's Address, to be delivered to the House of Delegates on May 8, 1972. His statements concerning Medical Advances Institute, H.R. 7182 and Professional Standards Review Organization were given the support and approval of the Council.

American Medical Association

Dr. Meiling, chairman of the Ohio delegation to the AMA, discussed deliberations of the Council on Long Range Planning and Development of the American Medical Association. He reported on a recommendation which would, in effect, destroy the present structure of the American Medical Association as a federation of county and state medical societies. The Council voted to instruct the Ohio delegation to present a resolution at the San Francisco meeting of the AMA in June opposing this recommendation, and further asked that such resolution be sent to other state medical societies in advance of the meeting along with a covering letter from Dr. Robechek. The following were appointed to the committee to prepare the resolution: Dr. Meiling, chairman, Drs. Henry, Budd and Schultz.

The minutes of a meeting of the Ohio delegation to the AMA, held February 11, 1972, were accepted for information.

A communication from the California Medical Association, dated February 11, 1972, with regard to representatives of medical school students being involved in organized medicine, was received for information.

Membership

Statistics

Mrs. Wisse, membership secretary, reviewed membership statistics for the information of the Council. She reported that total OSMA membership as of April 14, 1972 was 8,820. Based on December 31, 1971 membership figures, approximately 85% of OSMA dues are certified for 1972.

Report of Ohio Director of Health

Dr. John W. Cashman, Ohio Director of Health, addressed the Council. He discussed the increased role of the Ohio Public Health Council and the contributions of that body to the operation of his department. He announced that money is available in the biennium budget to add one hundred new employees to the department.

One of the key issues at this time, according to Dr. Cashman, includes the nursing home situation. At present the Department of Health is responsible for the licensing of nursing homes; the fire marshal's office in the Department of Commerce has certain inspection responsibilities; the Board of Building Standards in the Industrial Relations Department also has inter-related responsibilities; and the Department of Public Welfare distributes public funds in connection with the payment of nursing homes for welfare patients.

Dr. Cashman also discussed problems involving fluoridation, abortion, and a proposed legislative program contemplated by his department.

OSMA Annual Meeting

An application from the "Right to Life Society" for an exhibit at the 1972 Annual Meeting was reviewed by the Council. The opinion of the Council was that the exhibit is not appropriate for showing at the OSMA meeting.

The Council voted to honor Dr. Frederick T. Merchant, Marion, with a distinguished service citation of the Ohio State Medical Association.

(Continued on Page 573)



PROTEIN CONTENT/ 1 Cup Prepared Soup*

Bean with Bacon	7.7	Green Pea	7.8
Beef	9.1	Hot Dog Bean	8.6
Chicken Broth	8.4	Oyster Stew	6.0
Chicken 'N Dumplings	6.6	Pepper Pot	6.9
Chili Beef	7.0	Split Pea with Ham	11.6
Consomme	5.6	Vegetable Beef	5.7

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the 3 phases of Eve



All women are not equal in their endogenous hormonal output. And, while all oral contraceptives are fundamentally effective, they exhibit **differences** in **their activity levels** and **estrogen-progestogen ratios that affect different women differently**—in both short and long-term use. Some brands may be insufficient for the woman's needs or else may exceed them.

Searle offers a family of O.C. products that covers the range of women's needs to help you provide the right pill for the right woman at the right time.

References. **1.** Editorial. Oral Contraceptives. Which Pill for Which Patient? Patient Care *3*:90-115 (Feb.) 1969 and *4*:135-145 (June 15) 1970. **2.** Greenblatt, R. B. Progestational Agents in Clinical Practice, Med. Sci. *18*:37-49 (May) 1967. **3.** Kistner, R. W. Gynecology: Principles and Practice, ed. 2, Chicago, Year Book Medical Publishers, 1971. **4.** Kistner, R. W. The Pill: Facts and Fallacies About Today's Oral Contraceptives, New York, Delacorte Press, 1968. **5.** Nelson, J. H. Clinical Evaluation of Side Effects of Current Oral Contraceptives. J. Reprod. Med. *6*:50-55 (Feb.) 1971. **6.** Orr, G. W. Oral Progestational Agents: Therapy and Complications. S. Dakota J. Med. *22*:11-17 (Jan.) 1969.

the Ovulen phase

Most women* with a **balanced hormone profile a normal menses** do best on a middle-of-the-road p that is neither estrogen dominant nor strongly progestogen dominant.

(*Typical clues—normal body build and breasts feminine appearance, healthy skin and hair. Vagin cytology slide—balanced "pink and blue.")

Some women having problems on other O.C.s might do well on Ovulen.

Ovulen has a distinctive hormonal balance that combines moderate estrogenic activity with a slig progestogen dominance. It has an excellent recor of patient acceptance.

Ovulen®

Each white tablet contains: ethynodiol diacetate 1 mg./mestranol 0.1 mg.

SEARLE

For brief summary of prescribing information, see following page.



the Demulen phase

Many women* who secrete **more estrogen** than most do well on a pill with lower estrogen activity and an increased progestogen overbalance.

(*Typical clues—shorter, plumper, full-breasted, with glowing skin and no wrinkles. Vaginal cytology slide "pink.")

Some women with special conditions that may be aggravated by higher estrogen-activity products may do better on this ratio.

Demulen combines minimal estrogenic activity with a moderate ratio of progestogen overbalance. It is particularly well suited to the young when low-dose (activity) is preferred. Demulen offers little risk of the most potent progestogen side effects; early breakthrough bleeding is often transient.

Demulen®

Each white tablet contains: ethynodiol diacetate 1 mg / ethinyl estradiol 50 mcg

Each pink tablet in Ovulen-28* and Demulen®-28 is a placebo, containing no active ingredients.

Both Ovulen and Demulen are available in 21- and 28-pill schedules.

the Enovid-E phase

Some women* who secrete **less estrogen** than most do best on a pill with a moderate estrogen overbalance.

(*Typical clues—oily complexion, acne, hirsutism, masculinity, flat chest. Vaginal cytology slide—"blue.")

Patients with estrogen deficiency may show:

premenopausal syndrome
early-cycle bleeding
scanty menses
intermittent depression
increased appetite
steady weight gain
vaginal candidiasis

Enovid-E not only provides increased estrogenic activity with low progestogen activity, but also contains the only progestogen that is not antiestrogenic. Therefore it offers less risk of high-dose progestogen side effects.

Enovid-E®

Each tablet contains: norethynodrel 2.5 mg / mestranol 0.1 mg.

Oral contraceptives are complex medications and, after reference to the prescribing information, should be prescribed with discriminating care.

for the 3 phases of Eve:

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ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen®

Each white tablet contains:
ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1,3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possib influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrena hepatic or uterine function awaits further study. A decrease in glucose toleranc has been observed in a significant percentage of patients on oral contracep tives. The mechanism of this decrease is obscure. For this reason, diabetic p tients should be carefully observed while receiving Ovulen or Demulen therap The age of the patient constitutes no absolute limiting factor, although treatmer with Ovulen or Demulen may mask the onset of the climacteric. The pathologi should be advised of Ovulen or Demulen therapy when relevant specimens ar submitted. Susceptible women may experience an increase in blood pressur following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated betwee use of oral contraceptives and the following serious adverse reactions: thromb phlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relatio ship has been neither confirmed nor refuted for the following serious adver reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving or contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdon inal cramps and bloating), breakthrough bleeding, spotting, change in menstru flow, amenorrhea during and after treatment, edema, chloasma or melasm breast changes (tenderness, enlargement and secretion), change in weig (increase or decrease), changes in cervical erosion and cervical secretions, su pression of lactation when given immediately post partum, cholestatic jaundic migraine, rash (allergic), rise in blood pressure in susceptible individuals ar mental depression.

Although the following adverse reactions have been reported in users oral contraceptives, an association has been neither confirmed nor refute anovulation post treatment, premenstrual-like syndrome, changes in libid changes in appetite, cystitis-like syndrome, headache, nervousness, diz ness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiform erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contr ceptives: hepatic function: increased sulfobromophthalein retention and oth tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and thyroid function: increase in PBI and butanol extractable protein bound iodir and decrease in T^3 uptake values; metyrapone test and pregnanediol det mination.

References: 1. Royal College of General Practitioners: Oral Contrace tion and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 19 **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmona Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearin Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Inves gation of Relation Between Use of Oral Contraceptives and Thromboembo Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartw P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboer bolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Am J. Epidem. *90*:365-380 (Nov.) 1969.

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norethynodrel 2.5 mg./mestranol 0.1 mg.

Actions—Enovid-E acts to prevent ovulation by inhibiting the output gonadotropins from the pituitary gland. Enovid-E depresses the output of bo the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adver Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E a should be observed when prescribing Enovid-E.

SEARLE **Enovid-E®**
brand of norethynodrel with mestranol

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Where "The Pill" Began

County Medical Society Constitutions and Bylaws

Allen County

The amended Code of Regulations of the Academy of Medicine of Lima and Allen County, Inc., was **approved** as presented.

Gallia County

The revised Constitution and Bylaws of the Gallia County Medical Society were **approved,** subject to the establishment of specific dates for the quarterly meetings.

Stark County

The revised Constitution and Bylaws of the Stark County Medical Society were **approved,** with the exception of the rewording of Article V.

Committee Reports

OSMA-OSBA Liaison Committee

A resumé of the meeting March 8, 1972 of the Subcommittee on Medical Arbitration Plans of the Ohio State Medical Association and the Ohio State Bar Association Liaison Committee was presented by Dr. Fulton and was accepted for information.

Ad Hoc Committee on Health Care Delivery Systems

Minutes of the March 8, 1972 meeting of the Ad Hoc Committee for Study of Health Care Delivery Systems were presented by Mr. Gillen and were received for information.

Commission on Medical Education

The minutes of the March 15, 1972 meeting of the Commission on Medical Education were presented by Mr. Edgar. The Council voted that the Commission's report on Resolution 3-71, less appendices, be forwarded to the House of Delegates of the Ohio State Medical Association for consideration at the 1972 Annual Meeting.

The Council received for information a communication from Elvin C. Hedrick, M.D., Kettering, chairman of the OSMA Section on Medical Education, along with an article on "Proposals for Financing Health Care and Medical Education" by Jack H. Hall, M.D., Director of Medical Education, Methodist Hospital, Indianapolis, Indiana and President of the Association for Hospital Medical Education.

A communication from the American Academy of Physicians' Associates, Durham, North Carolina, dated March 30, 1972, was referred to the Commission on Medical Education.

Committee on Mental Health

Minutes of a meeting of the Committee on Mental Health on March 19, 1972 were presented by Mr. Clinger.

Approval of the minutes included approval of the committee's recommendations that there be established a joint liaison committee of the OSMA, the Ohio State Medical Board and Ohio State Board of Pharmacy to consider means—within the realm of peer review—for the control of prescriptions involving narcotics and other dangerous drugs.

The Council also **approved** the committee's recommendation that the Ohio State Medical Association oppose House Bills 621 and 756, both concerning changes in procedures for hospitalization of the mentally ill.

The Council accepted the recommendation of the committee that the OSMA endorse, in principle, better coverage of mental health benefits in hospitalization insurance and that such be given extensive study by legal counsel and the OSMA Committee on Insurance.

A communication dated April 10, 1972 from Charles M. Kennedy, Systems Development Manager, Department of Mental Health and Mental Retardation, Ohio Department of Mental Hygiene and Correction, concerning the development of a work group which will address itself to the problem of qualifying non-medical personnel as managing officers of state institutions, was referred to the Committee on Mental Health.

Drug Abuse Seminar

The Council **approved** the participation of the OSMA, with the Department of Mental Hygiene and Correction and the Pfizer Company, in the sponsorship of a Drug Abuse Seminar, with the implementation of the seminar being referred to the Committee on Mental Health.

Committee on Laboratory Medicine

Mr. Rader presented the minutes of a meeting of the Committee on Laboratory Medicine held March 22, 1972.

The Council **approved** the recommendation of the committee that H.B. 994, to require sickle cell disease testing during the premarital blood test, be opposed; and that H.B. 1024, to instruct the Ohio Department of Health to participate in the rehabilitation and counseling of persons with sickle cell disease, **be approved.**

The request of the committee, that the OSMA Committee on School Health and the Committee on Laboratory Medicine attempt to study the development of a comprehensive program of health education and testing to be used

during the public education process in the area of sickle cell disease and other generic diseases, **was amended and approved.**

Committee on Membership and Planning

Dr. Schultz and Mr. Gillen presented the minutes of a meeting of the Committee on Membership and Planning held March 25, 26, 1972.

The Council discussed the results of a pilot study of a survey of consumers' opinions on health and medical care delivery systems and the image of the physician, conducted by a professional survey organization under the supervision of the Committee on Membership and Planning. The Council favored extending this project, contingent on financing, and the Committee on Auditing and Appropriations was designated to develop resources for this purpose.

Also approved by the Council was the committee's suggestion that 300 non-members be surveyed for their reasons for not joining the Ohio State Medical Association.

A recommendation of the committee, that it meet with the presidents of the specialty societies for the purpose of discussing the possibility of providing assistance to these groups, was favorably acted upon by the Council.

Final approval was granted for the revision of the "Services and Activities" pamphlet of the OSMA.

The Council also endorsed the suggestion of the committee that there be periodic meetings of the Council with the local executive secretaries.

Committee on Eye Care

The minutes of a meeting of the Committee on Eye Care, held on February 29, 1972, were presented by Mr. Rader and they **were approved.**

Included in the minutes was the recommendation that members of ophthalmology and opticianry meet to discuss the principles involved in the opticianry legislation and to draft a new bill in lieu of Sub. H.B. 474.

Committee on School Health

Mr. Clinger presented the minutes of a meeting on March 29, 1972 of the Committee on School Health. The minutes were amended and **approved.**

Policy recommendations included:

1. That physical examinations be mandatory for all children being considered for placement in special education programs in Ohio.

2. That the Ohio State Medical Association adopt and support the AMA statement on sickle cell disease, enacted by the AMA House of Delegates at the 1971 Clinical Convention. The statement is as follows:

"RESOLVED, That research efforts directed to the prevention of sickle cell crises and development of treatment forms to reverse the sickling process be encouraged; and be it further

"RESOLVED, That the American Medical Association encourage efforts to evaluate the effectiveness of screening and counseling programs for sickle cell trait and sickle cell disease; and be it further

"RESOLVED, That the American Medical Association support ongoing research programs to identify the characteristics of sickle cell disease and develop effective treatment programs."

3. That the Committees on School Health and Laboratory Medicine jointly sponsor a dinner meeting for the House HEW subcommittee and concerned physicians in order to discuss all aspects of sickle cell disease and related legislation—and that the meeting be held, if possible, prior to the 1972 OSMA Annual Meeting.

4. That the Ohio Revised Code be amended to provide for the discontinuance of the requirement for Pertussis immunization for children after their seventh birthday.

A recommendation that a physical examination be mandatory for all children being considered for placement in vocational education programs in Ohio was rereferred to the committee for further study.

Council Fee Review Committee

Dr. Ivins presented the minutes of a meeting of the Council Fee Review Committee held on April 14, 1972.

The Council accepted the committee's recommendation that no action be taken on the case before the committee at this time and that it be rereferred to the Bureau of Workmen's Compensation for clarification of the treatment given. In addition, the Council recommended that the Bureau of Workmen's Compensation not pay the bill until sufficient evidence is provided by the physician.

Auditing and Appropriations Committee

A report on the meeting of the Auditing and Appropriations Committee, held on April 16, 1972, was presented by Mrs. Wisse and was accepted for information.

Ohio Medical Indemnity Liaison Committee

A report of the Liaison Committee of Ohio Medical Indemnity, Inc., was presented by Mr. Page. He announced that OMI plans to renegotiate the expense sharing formulae with Blue Cross Plans in Ohio; that the unassigned reserve of the company is equivalent to three months of operating expense; that the general reserve amounts to $22,158,000; that assets increased $8,307,000 from February, 1971 to February, 1972; and that earned income February, 1972 was $7,903,000, indicating that the company will soon be a $100,000,000 business. He announced that of the group coverages, "usual, customary and reasonable" constituted 52.95 percent of the total contracts, standard contracts 4.68 percent, preferred 21.8 percent and major 15.9 percent.

Mr. Page reported on the annual business meeting of Blue Shield Plans in Chicago, April 8-10, 1972. A supplemental report of the president, Mr. Ned F. Parish, was distributed to the Council.

Council requested that OMI explore the feasibility of providing coverage for physician members of the Ohio State Medical Association and their employees.

Mr. M. Jerry Ketchum, President of Ohio Medical Indemnity, Inc., and Mr. Homer Harrison, Vice President of Marketing and Professional Relations, were guests of the Council and discussed various developments in the Blue Shield program.

A letter dated February 8, 1972, from the Summit County Medical Society to Ohio Medical Indemnity, Inc., was received for information.

Medicare Law

A communication from Dr. J. R. Sheets, Portsmouth, regarding Medicare, was presented to the Council. The Council expressed itself as being aware of his concern and assured that the Association will do all that is possible to make certain that the Medicare law is complied with in a proper manner.

Health Maintenance Organizations

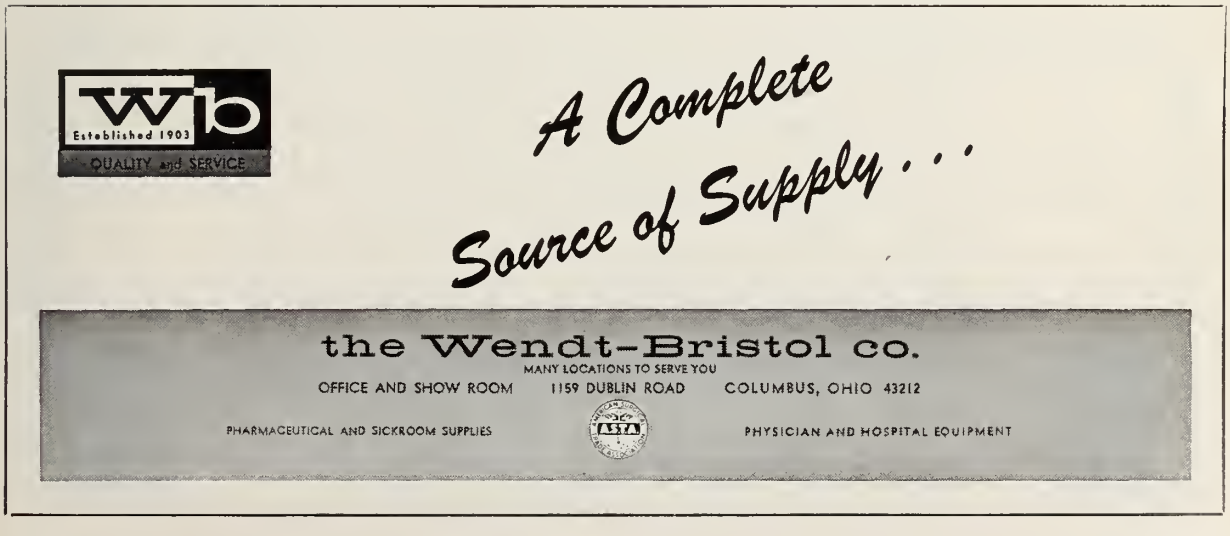
A statement dated April 4, 1972 of J. F. Follmann, Jr., vice president of the Health Insurance Association of America, describing health maintenance organizations (HMOs) today as one answer to the nation's health care delivery and financing problems and stating that private insurers are fully behind this new type of health planning, was received for information.

Aetna's Prevailing Fee Schedule

A communication dated April 4, 1972 from the Louisiana State Medical Society to Mr. Don Johnson, President of the Aetna Life and Casualty Insurance Company, Hartford, Connecticut, concerning Aetna's "prevailing fee schedule" was received for information.

"Health Lines" Radio Program

The Council **approved** the "Health Lines" radio program, with the project being closely co-



ordinated with the OSMA Department of Public Relations through the county medical societies.

Federal Legislation

Mr. Edgar gave an informal report to Council on Federal legislation.

Washington Visitation

The Council **approved** preliminary plans for a Washington visitation to take place about January, 1973.

State Legislation

The President was authorized to appoint a committee to assist the legal counsel in the drafting of legislation with regard to podiatry.

S.B. 496—To provide protection for dental peer review committees. Action: **The Council instructed that the bill be amended to include physicians and doctors of osteopathic medicine and surgery.**

H.B. 994—Premarriage blood test for sickle cell anemia. Action: **Opposed.**

H.B. 1024—Sickle cell disease programs. Action: **Approved.**

H.B. 621 — Legal counsel and protection against involuntary treatment in mental hospital commitments. Action: **Opposed.**

H.B. 756—To alter the procedures for hospitalization of the mental ill. Action: **Opposed.**

Am. S.H.B. 474—A bill to license opticians. Action: **Present bill unsatisfactory. New bill to be drafted.**

Labeling legislation—It was Council's expression that if legislation is introduced to provide for the labeling of prescriptions the product be labeled by its brand name, with the physician's discretion to omit labeling being preserved. It was Council's opinion that labeling by generic name would be a decided disadvantage in cases of drug emergencies.

Retiring Officers Thanked

Dr. Robechek thanked the Council for its support during the past year and the Council expressed its appreciation to him and to the retiring members of the Council—Drs. Becker, Ivins and Press—for their dedication and devotion.

The Council expressed its thanks and appreciation to Dr. Richard L. Fulton, retiring past president, for his years of dedicated service on the Council as councilor, president-elect, president and past president of the Association.

There being no further business, the Council adjourned.

ATTEST: Hart F. Page
Executive Director

OSMA Group Term Life Insurance offers:

***tax savings for professional corporations**
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Group ordinary life insurance, disability, and Business Overhead Expense plans also available. Contact:

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He won't resist feeling better with Mylanta®

Because the taste is good.

- □ promptly relieves hyperacidity
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LIQUID **MYLANTA**® TABLETS

aluminum and magnesium hydroxides with simethicone

STUART PHARMACEUTICALS | Division of ICI America Inc. | Wilmington, Del. 19899 | Pasadena, Calif. 91109



a new outlook in chronic pain

of moderate to severe intensity

Though Talwin® can be compared o codeine in analgesic efficacy, it is not a narcotic. So patients receiving Talwin for prolonged periods face fewer of he consequences you've come to expect with narcotic analgesics. And that, in the long run, can mean a better outlook for your chronic-pain patient.

Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used v caution in patients about to undergo surgery of the biliary tr

Patients Receiving Narcotics. Talwin is a mild narcotic antagor Some patients previously receiving narcotics have experienced r withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administe to patients prone to seizures; seizures have occurred in a few s patients in association with the use of Talwin although no cause effect relationship has been established.

Adverse Reactions: Reactions reported after oral administra of Talwin include *gastrointestinal:* nausea, vomiting; infreque constipation; and rarely abdominal distress, anorexia, diarr *CNS effects:* dizziness, lightheadedness, sedation, euphoria, h ache; infrequently weakness, disturbed dreams, insomnia, sync visual blurring and focusing difficulty, hallucinations (see *A CNS Manifestations* under WARNINGS); and rarely tremor, i tability, excitement, tinnitus. *Autonomic:* sweating; infreque flushing; and rarely chills. *Allergic:* infrequently rash; and ra urticaria, edema of the face. *Cardiovascular:* infrequently decr in blood pressure, tachycardia. *Other:* rarely respiratory depress urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dos 1 tablet (50 mg.) every three or four hours. This may be incre to 2 tablets (100 mg.) when needed. Total daily dosage should exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in a tion to analgesia, aspirin can be administered concomitantly v Talwin.

Children Under 12 Years of Age. Since clinical experience in dren under 12 years of age is limited, administration of Talwi this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have rece Talwin orally for prolonged periods have not experienced w drawal symptoms even when administration was abruptly dis tinued (see WARNINGS). No tolerance to the analgesic effect been observed. Laboratory tests of blood and urine and of liver kidney function have revealed no significant abnormalities a prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin o dosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and o supportive measures should be employed as indicated. Assiste controlled ventilation should also be considered. Although na phine and levallorphan are *not* effective antidotes for respira depression due to overdosage or unusual sensitivity to Talwin, enteral naloxone (Narcan®, available through Endo Laboratorie a specific and effective antagonist. If naloxone is not available, enteral administration of the analeptic, methylphenidate (Ritali may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet cont Talwin (brand of pentazocine) as hydrochloride equivalent to 50 base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (15

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

Real Gut Fighting Will Take Place in Legislative Races

"A lot of people will be looking at the top of the ticket, the presidential race, and will overlook the Legislative races. That's where the real gut fighting this fall will be and there's where we are going to be in there pitching."

Thus spoke one of the party political chiefs of Ohio not too long ago.

To say that the medical profession has a big stake in the legislative races . . . Congress and Ohio General Assembly . . . this year is putting it mildly.

Are you willing and prepared to get in and pitch?

The pre-election investigating machinery of the Ohio State Medical Association and the County Medical Societies, if operated at its peak, can turn up information on the candidates which will be of great assistance to you in making up your mind which candidates to support.

See that your County Medical Society legislative committee gets on the ball on this. Ask it to relay the information to society members. Candidates who win the approval of county medical societies throughout the state are the ones who will be given campaign financial aid by OMPAC if they need more campaign money than available through regular party and private sources.

* * * *

Good quotes from a recent pamphlet on fund raising for political campaigns:

"Nothing is more important than to raise and contribute money judiciously.

"What good is a philosophy if the voters never hear of it?

"How good is a slogan if you and your candidate merely shout it to yourselves.

"Modern media works miracles, but in order to make the media work, it takes money.

"Money is not an elective. It is part of the curriculum in an effective political campaign."

Have you made your 1972 Ohio Medical Political Action Committee contribution?

* * * *

Here are some facts of life you can point out to your Congressman the next time you talk or write to him . . . other folks, too, as a matter of fact.

The Social Security Administration, in a recently published breakdown, reveals that physicians' fees accounted for only 19 percent of the total amount of money spent for medical care nationally during the fiscal year ending last June 30. Too many people, too often get the idea that physicians get most of the medical care cost dollar. 'Tain't so. Let folks know.

Here's how the fiscal 1971 health care dollar was spent to make up the $75-billion total:

- Hospitals—$29.6 billion.
- Physicians—$14.2 billion.
- Dentists—$4.7 billion.
- Other professional services—$1.5 billion.
- Drugs—$7.5 billion.
- Eyeglasses—$1.9 billion.
- Nursing homes—$3.4 billion.
- Expenses for prepayment and administration—$2.3 billion.
- Governmental public health—$1.6 billion.
- Other health services—$2.8 billion.
- Research and medical facilities construction—$5.5 billion.

Ohio Medical Political Action Committee

When you prescribed Orinase®

(tolbutamide, Upjohn)

14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessa for optimal control with insulin are also necessary with Orina The patient on Orinase must be fully instructed: about t nature of his disease; how to prevent and detect complicatio how to control his condition; not to neglect dietary restrictio develop a careless attitude or disregard instructions relative body weight, exercise, personal hygiene, and avoidance of fection; how to recognize and counteract impending hypog cemia; how and when to test for glycosuria and ketonuria; h to use insulin; and to report to the physician immediately if does not feel as well as usual.

Caution, very close observation, and careful adjustment dose are necessary when: insulin is withdrawn during the t period in order to avoid ketosis, acidosis, and coma; thiaz diuretics are administered which may result in aggravation diabetic state and increased tolbutamide requirement, tem rary loss of control, or even secondary failure; treating patie with impaired hepatic and/or renal function and debilitated, n nourished, or semistarved patients in order to avoid severe hy glycemia which may require corrective therapy over sev days; and treating patients with severe trauma, infection, or gical procedures where temporary return to insulin or addi of insulin may be necessary. Response to tolbutamide is dir ished in patients receiving therapy with beta blocking age

As some diabetics are not suitable candidates, it is esse that the physician familiarize himself with the indications, li of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, during the initial test period should communicate with the ph

Today you have your own.

If you're around 40 or 45, you've ɔbably had quite a bit of clinical experience :h Orinase.

Maybe as much as 14 years.

And that means you know quite a about it.

On the one hand, you know that diet d weight control are the initial and essential ndations for the management of adult-set, non-ketotic diabetes. When these asures prove satisfactory, no additional rapy is indicated. On the other hand, you ow that if these measures fail the addition of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

In short, Orinase is a drug you're familiar with, and probably have confidence in.

And that may be the best recommendation Orinase can have.

Orinase®

0.5 g. tablets

(tolbutamide, Upjohn)

an daily, and during the first month report at least once weekly r physical examination and definitive evaluation. After a month, aminations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory wering or persistent elevation of blood sugar, or failure to otain and hold clinical improvement indicate nonresponsiveess to Orinase (tolbutamide). Orinase does not obviate need for aintaining standard diet regulation. Uncooperative patients ould be considered unsuitable for therapy. Prescriptions should e refilled only on specific instruction of physician. In treating ild asymptomatic diabetic patients with abnormal glucose lerance, glucose tolerance tests should be obtained at three- six-month intervals. Orinase is not an oral insulin or a substiute for insulin and must not be used as sole therapy in juvenile iabetes or in diabetes complicated by acidosis or coma where nsulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, ay occur and may mimic acute neurologic disorders such as erebral thrombosis. Certain factors such as hepatic and renal isease, malnutrition, advanced age, alcohol ingestion, and drenal and pituitary insufficiency may predispose to hypoglyemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine xidase inhibitors, phenylbutazone, bishydroxycoumarin, and henyramidol may prolong or enhance the action of Orinase and ncrease risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001

Upjohn

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Venereal Disease Treatment Schedule

Recommended by the Ohio Department of Health

SYPHILIS

Penicillin is the drug of choice for the treatment of all stages of syphilis. Penicillin is available upon request (see under V, Requests for Drugs) for the treatment of indigent syphilitics.

TREATMENT SCHEDULE

PRIMARY AND SECONDARY SYPHILIS

Rx: Benzathine penicillin G — Total dosage: 2.4 million units, (1.2 million units in each buttock) by intramuscular injection.

or: Procaine penicillin (PAM) — Total dosage: 4.8 million units (2.4 million units at first session, as above, and 1.2 million units at each of the two subsequent injections, 3 days apart)

or: Aqueous procaine penicillin G — Total dosage: 4.8 million units (600,000 units daily for 8 days).

LATENT SYPHILIS — Early Latent Syphilis (Less than 2 years duration — history of negative STS within past 2 years) and Late Latent Syphilis (more than 2 years duration — no history of negative STS within past 2 years)

Rx: Benzathine penicillin G — When the results of a spinal fluid examination are not known, treatment must encompass the possibility of asymptomatic neurosyphilis. In this case total dosage 6.0-9.0 million units, given 3.0 million units, (1.5 million units in each buttock each session) at 7 day intervals.
With nonreactive spinal fluid examination, 2.4 million units total (1.2 million units in each buttock) — same as primary syphilis.

or: PAM — same as primary syphilis.

or: Aqueous penicillin G — same as primary syphilis.

EARLY CONGENITAL SYPHILIS (under 2 years)

Rx: Benzathine penicillin G — (50,000 units per Kg. of body weight) total dose administered as a single intramuscular injection.

or: Procaine penicillin — 100,000 units per Kg. of body weight (given in divided daily dosage over 10-day period)

or: Aqueous procaine penicillin — same as (PAM) penicillin.

*LATE CONGENITAL SYPHILIS (over 2 years)

Rx: Benzathine penicillin G — 6.0-9.0 million units total (3.0 million units: 1.5 million units in each buttock at each session) at 7 day intervals: when the results of a spinal fluid examination are not known.

or: Procaine penicillin — Total dosage: 6.0-9.0 million units (2.4 million units: 1.2 million units in each buttock at the first session). and 1.2 million units at each subsequent session 3 days apart.

or: Aqueous procaine penicillin — 6.0-9.0 million units total (600,000 units daily).
With nonreactive spinal fluid, 2.4 million units (1.2 million units in each buttock given at a single session).

NEUROSYPHILIS AND CARDIOVASCULAR SYPHILIS

Rx: Benzathine penicillin G — Same as Late Congenital Syphilis.

or: Procaine penicillin — Same as Late Congenital Syphilis.

or: Aqueous procaine penicillin — Same as Late Congenital Syphilis.

(Continued on Page 587)

*NOTE: In treating Late Congenital Syphilis in patients under 12 years of age, dosage of penicillin should be adjusted for age and weight.

The accompanying article is the revised schedule of the Venereal Disease Treatment Schedule recommended by the Ohio Department of Health. It was forwarded to *The Journal* by John H. Ackerman, M.D., Chief of the Division of Communicable Diseases of the Ohio Department of health, with the statement, "The Ohio State Medical Association's active participation in venereal disease control is essential to the success of this program."

140/90 is normal blood pressure...or is it?

An extensive study based on nearly 4 million life insurance policies suggests that a blood pressure reading of 140/90 requires close medical supervision.

Study Findings. Twelve years ago the Society of Actuaries reported on an extensive study based on the lives and deaths represented by almost 4 million life insurance policies. From this vast survey—"The Build and Blood Pressure Study"[1]—insurance experts concluded that:

- Blood pressure above 140/90 is accompanied by increased morbidity and requires close medical attention.
- Even small increments in either systolic or diastolic blood pressure progressively and steeply shorten life expectancy.

Other Studies. Studies conducted with large numbers of patients since that time have echoed the above findings. Two studies published in 1970—the VA Cooperative Study Group on "Effects of Treatment on Morbidity in Hypertension"[2] and the "Framingham Study"[3]—suggest that treatment of even mild hypertension may, over time, offer significant benefits to the patient.

Another Point of View. Although a growing body of studies suggests that treatment of mild hypertension is warranted, medical opinion is not unanimous. Some clinicians recommend that drug treatment for mild hypertension be reserved for patients with additional risk factors such as smoking, high cholesterol levels, heart or kidney involvement, or a family history of vascular disease. Dr. Walter M. Kirkendall stated this position in his recent paper "What's With Hypertension These Days?"[4] Discussing the management of hypertension in patients with a sustained diastolic pressure up to 100 mm Hg, he said: "Generally, I do not recommend antihypertensive therapy unless patient's blood pressure approaches the upper limit for the group and a number of adverse factors exist, such as male sex, family history of vascular disease, youth, evidence of heart or kidney involvement."



Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

MSD
MERCK SHARP & DOHME

25- and 50-mg tablets

HydroDIURIL®
(Hydrochlorothiazide|MSD)

Therapy to Start With

For a brief summary of prescribing information, please see next page.

1. Society of Actuaries, *The Build and Blood Pressure Study*, 1959.
2. Veterans Administration Cooperative Study Group on Antihypertensive Agents, "Effects of Treatment on Morbidity in Hypertension," JAMA *213*:1143-1152, Aug. 17, 1970.
3. Dannel, William B., *et al.*: "Epidemiologic Assessment of the Role of Blood Pressure in Stroke—The Framingham Study," JAMA *214*:301-310, Oct. 12, 1970.
4. Kirkendall, Walter M.: "What's With Hypertension These Days?" Postgraduate Consultant, Jan. 1971.

25- and 50-mg tablets

HydroDIURIL®

(Hydrochlorothiazide|MSD)

Therapy to Start With

Drug Therapy for Hypertension. Although opinion varies on when to start drug therapy for mild hypertension, many physicians agree that treatment should start with a thiazide diuretic such as HydroDIURIL. For the adult patient, the usual starting dosage is 50 mg b.i.d. Dosage adjustments are recommended as the patient responds to treatment. The patient whose therapy begins with HydroDIURIL frequently can continue to benefit from it, because HydroDIURIL usually maintains its antihypertensive effect even when therapy is prolonged.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to this compound. Nursing mothers; if use of drug is deemed essential, patient should stop nursing.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function to avoid cumulative or toxic effects. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis.

When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents, especially ganglion blockers, must be reduced by at least 50% because HydroDIURIL potentiates their action.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery was frequently required, and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.

Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus, such as fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives, including thiazides.

PRECAUTIONS: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop (especially with brisk diuresis) in severe cirrhosis; with concomitant steroid or ACTH therapy; or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypokalemia may be avoided treated by use of potassium chloride or giving foo with a high potassium content. Similarly, any chlori deficit may be corrected by use of ammonium chlori (except in patients with hepatic disease) and larg prevented by a near normal salt intake. Hypochloren alkalosis occurs infrequently and is rarely severe. severely edematous patients with congestive failure renal disease, a low salt syndrome may occur if diet salt is unduly restricted, especially during hot weath

Thiazides may increase responsiveness to tubo rarine. The antihypertensive effect of the drug may enhanced in the postsympathectomy patient. Arte responsiveness to norepinephrine is decreased, nec sitating care in surgical patients. Discontinue drug hours before elective surgery. Orthostatic hypotensi may occur and may be potentiated by alcohol, barb urates, or narcotics.

Pathological changes in the parathyroid glands w hypercalcemia and hypophosphatemia have been s in a few patients on prolonged thiazide therapy. T effect of discontinuing thiazide therapy on serum cium and phosphorus levels may be helpful in asse ing the need for parathyroid surgery in such patie Parathyroidectomy has elicited subjective clinical i provement in most patients, but has no effect hypertension. Thiazide therapy may be resumed a surgery.

Use cautiously in hyperuricemic or gouty patie gout may be precipitated. May affect insulin requi ments in diabetics; may induce hyperglycemia glycosuria in latent diabetics.

ADVERSE REACTIONS: Rare reactions incl thrombocytopenia, leukopenia, agranulocytosis, apl tic anemia, cholestasis, and pericholangiolitic hepati Nausea, vomiting, diarrhea, dizziness, vertigo, par thesias, transient blurred vision, sialadenitis, purp rash, urticaria, photosensitivity, or other hyperse tivity reactions may occur. Cutaneous vasculitis p cipitated by thiazide diuretics has been reported elderly patients on repeated and continuing expos to several drugs. Scattered reports have lin thiazides to pancreatitis, xanthopsia, neonatal thr bocytopenia, and neonatal jaundice. When adv reactions are moderate or severe, the dosage thiazides should be reduced or therapy withdra

For more detailed information, consult your MSD Representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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GONORRHEA

The drug of choice for the treatment of gonorrhea is penicillin.

Aqueous procaine penicillin G is available upon request for the treatment of indigent gonorrhea patients (see V, Request for Drugs).

TREATMENT SCHEDULE

***Males or Females**

Rx: Aqueous procaine penicillin G — 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to the injection.

PENICILLIN SENSITIVITY

Males

Rx: Spectinomycin, 2 grams, in one intramuscular injection.

Females

Rx: Spectinomycin, 4 grams, in one intramuscular injection.

OR

Males or Females

Rx: Tetracycline HCl, 1.5 grams initially, followed by 0.5 gram four times a day for 4 days, a total dosage of 9 grams.

All female contacts to male gonorrhea patients should receive preventive treatment. Studies have shown that at least 60 percent of such contacts are infected. Preventive treatment is carried out per the treatment schedule for female gonorrhea patients. Serologic Test for syphilis (STS) before preventive treatment.

Routine interviews of female gonorrhea patients for contacts have not proven to be worthwhile.

NOTE: Report morbidity to the Ohio Department of Health.

***NOTE:** When possible, probenecid should be administered as a single oral dose of 1 gram (Two 0.5 gram tablets) 30 to 45 minutes prior to the administration of penicillin therapy. Probenecid acts as a catalyst in increasing the blood levels of penicillin and most studies have shown a significant decrease in penicillin failure rates when this regimen is followed.

GENERAL INFORMATION

I. Follow-up

A. Primary, Secondary, Early Latent, and Early Congenital Syphilis:

1. Clinical evaluation by quantitative STS monthly for 6 months, then at 3 month intervals for 1 year.
2. If only one spinal fluid examination is to be done, the preferred time is 12 month post-treatment.

B. Late Latent Syphilis:

1. Quantitative STS at 6 month intervals for 2 years. Either a stable or falling titer may be considered satisfactory.
2. Persistence of reactive STS alone must not be considered as need for retreatment.

C. Late Congenital Syphilis:

1. If spinal fluid examination is nonreactive, quantitative serology at 6 month intervals for 2 years.
2. If spinal fluid is reactive, quantitative serology and spinal fluid examination at 3 month intervals for first year, and at 6 month intervals for second year.

D. Neuro and Cardiovascular Syphilis:

1. Same as congenital with reactive spinal fluid.

NOTE: All infectious syphilis patients must be interviewed for contacts. Assistance can be secured from the local health department or the Ohio Department of Health. Treatment should not be considered complete until all source and spread cases are located and placed under adequate medical supervision.

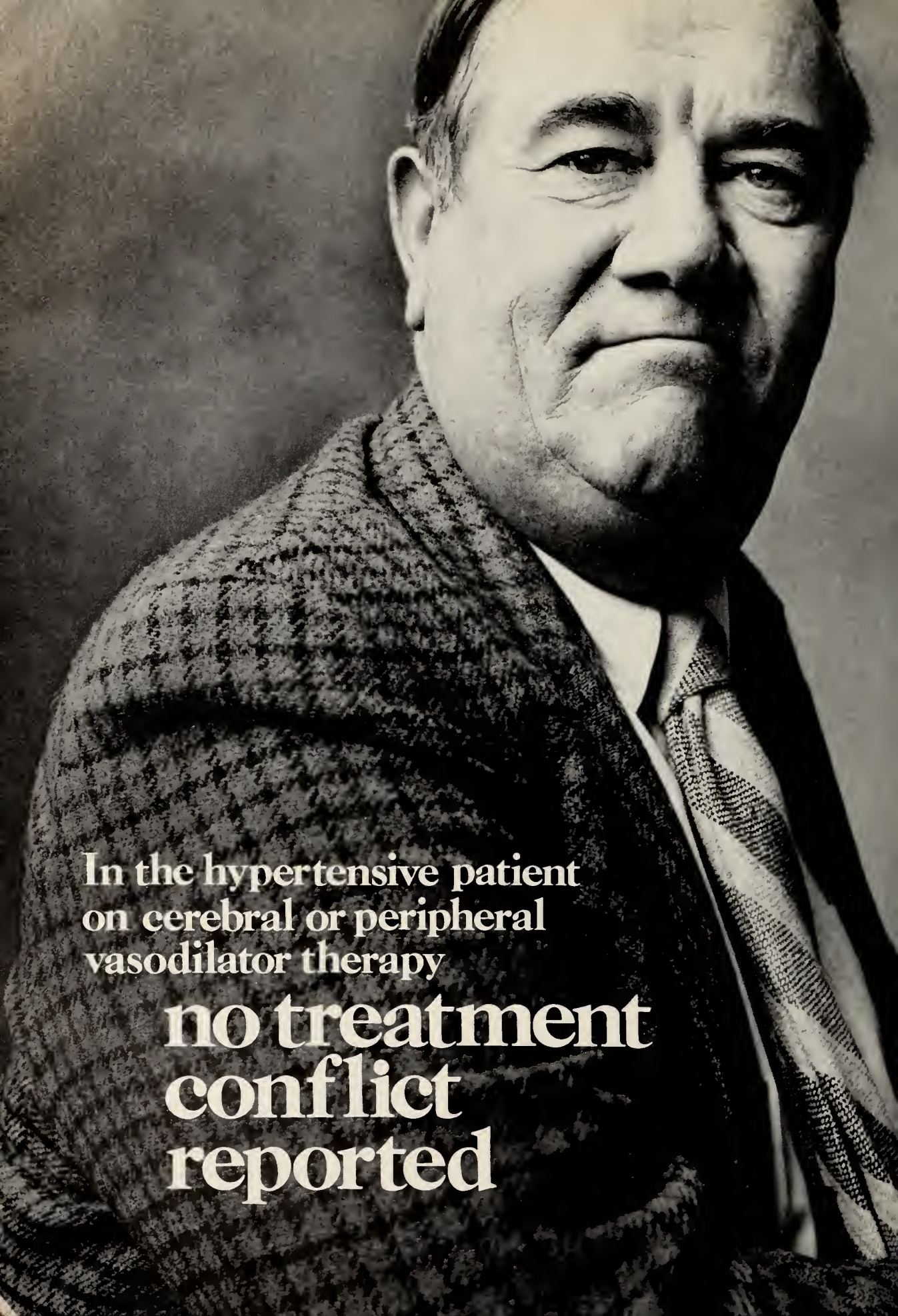
II. Penicillin Sensitivity

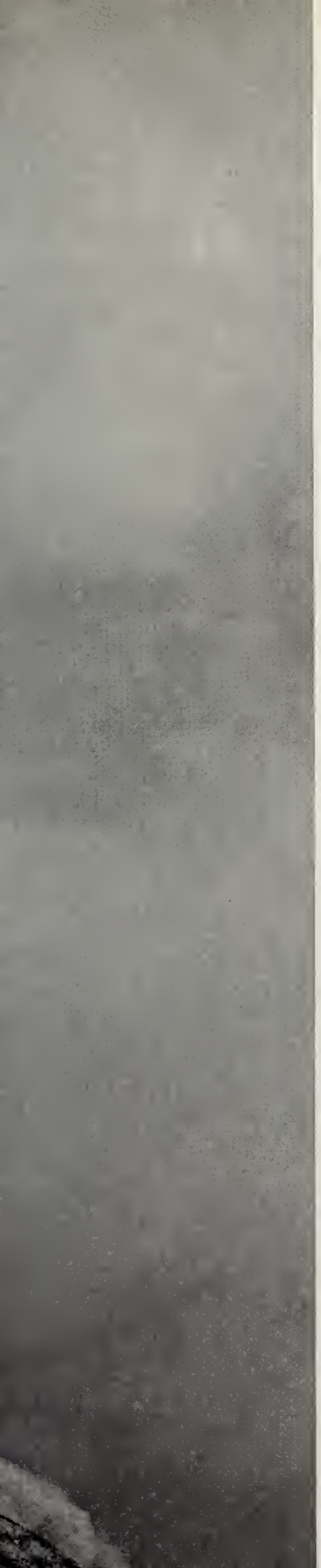
A. Penicillin should never be administered to any one who has had a previous penicillin reaction in any form.

B. Penicillin should never be administered intra-muscularly unless the patient may be observed for 15 to 30 minutes following treatment.

C. Penicillin sensitive patients can be treated with 30-40 gms. of erythromycin or one of the tetracycline compounds given 3 gms. daily for thirteen days; 15 days for neuro-syphilis or cardiovascular syphilis.

(Continued on Page 590)


In the hypertensive patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported



VASODILAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- has not been reported to complicate the treatment of hypertension.
- conflicts have not been reported with concurrently administered antihypertensives, diuretics, corticosteroids or miotics.
- complications in the treatment of diabetes, peptic ulcer, coronary insufficiency, glaucoma or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]

Composition: VASODILAN tablets, isoxsuprine HCl, 10 mg. and 20 mg. VASODILAN syrup, isoxsuprine HCl, 10 mg. per 5 ml. teaspoonful. **Indications:** *In cerebral vascular disorders,* for relief of symptoms due to vascular insufficiency associated with various conditions such as arteriosclerosis and hypertension. *In peripheral vascular disorders,* for relief of symptoms such as intermittent claudication, coldness, numbness, pain and cramping of the extremities—in the management of arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Dosage and Administration:** In peripheral and cerebral vascular disorders—10 to 20 mg. three or four times daily. **Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. **Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose. **Supplied:** *Tablets,* 10 mg.—bottles of 100 and 1000, and Unit Dose; 20 mg.—bottles of 100 and 500. *Syrup,* 10 mg. per 5 ml. teaspoonful—bottles of 1 pint.

References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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(VD Treatment Schedule—*Continued*)

D. Tetracycline is available to physicians who treat indigent penicillin sensitive patients. (see #V, Request for Drugs).

III. When to Retreat

A. Any treated syphilitic may, at a later date, need additional treatment. The following are conditions under which this is indicated:

1. Syphilis in pregnancy when adequacy of previous therapy is not determinable;
2. Persistently active neurosyphilis;
3. Relapse;
4. Reinfection;
5. Exposure to a known infectious case of syphilis-preventive treatment.

B. Treatment for the sole purpose of obtaining a nonreactive serological test for syphilis is expensive, often futile, and cannot be considered sound practice.

IV. Preventive Treatment

A. If the patient is known to have been exposed to lesion syphilis, it is a fallacy to wait for the disease to develop to the clinical or reactive serologic stage, meanwhile allowing reinfection of treated patients and the infection of additional persons. However, every effort should be made to arrive at a diagnosis, including a complete physical examination, before administering preventive treatment.

B. Adequate preventive treatment may consist of 2.4 million units of benzathine penicillin G.

C. Penicillin is available to physicians for the treatment of indigent sexual contacts to infectious syphilis upon completion of appropriate forms as outlined in #V below.

V. Requests for Venereal Disease Drugs

A. Requests for drugs for the treatment of venereal diseases must be submitted on

(Continued on Page 593)

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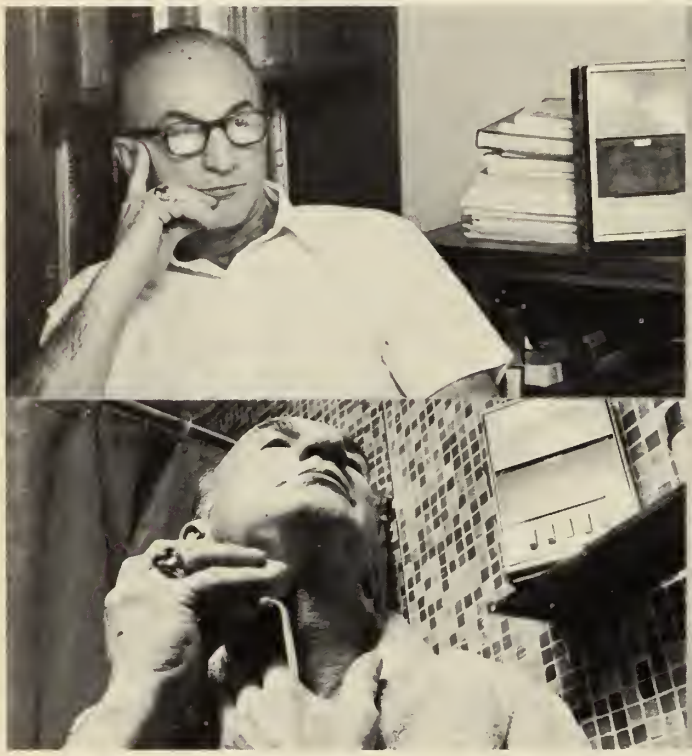
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Order and Receipt for Drugs and/or Biologicals (Form #3332.02 ODH). Requisitions will not be filled unless the appropriate form(s) are fully completed and attached to Order and Receipt for Drugs and/or Biologicals. (see 1 and 2 below).

1. Private Physician's Requisition for Venereal Disease Drugs — Form #3815.11 ODH.

   a. Penicillin is available to physicians upon completion of Form #3815.11 for the treatment of indigent syphilitics and sexual contacts to infectious syphilis.

   b. Aqueous procaine penicillin G is available to physicians upon completion of Form #3815.11 for treatment of indigent gonorrhea patients and sexual contacts.

   c. Requests must be forwarded to the local health department in the health jurisdiction in which the physician is practicing. It is imperative that the request be validated by both the requesting physician and the local health officer prior to being forwarded to ODH.

2. Quarterly Requisition of Drugs for Treatment of Venereal Diseases by Cooperating Clinics—Form #3863.-11 ODH.

B. All requests for venereal disease drugs are to be forwarded from the local health department to:

The State of Ohio Department
of Health
Division of Communicable Diseases
V.D. Unit
450 East Town Street
P.O. Box 118
Columbus, Ohio 43215

C. Additional forms may be obtained from local health departments or ordered from the Ohio Department of Health Property and Supply Unit.

NOTE: Trade names are used for identification only and do not represent an endorsement.

VI. Follow-up (Gonorrhea)

A. Serologic test for syphilis (STS) before treatment. Patients receiving the recommended penicillin schedules need not have follow-up serologic tests for syphilis. Patients treated with Tetracycline or other alternate antibiotics should have a follow-up serologic test each month for 4 months to detect syphilis that may have been masked by gonorrheal therapy.

VII. Retreatment

A. If the discharge in uncomplicated gonorrhea persists for five or more days after initial adequate treatment and smear or culture is still positive, retreatment is indicated.

   1. Retreatment with Aqueous procaine penicillin G:

      Retreatment consists of doubling the original dosage given, either at a single visit or in divided doses on two successive days.

Obituaries

Percy Hammond Blount, M.D., Columbus; Meharry Medical College School of Medicine, 1923; aged 80, died April 20; member of OSMA and AMA; general practitioner in Columbus for some 40 years; veteran of World War I. Dr. Wilbur C. Blount, of Lorain, is his son.

George Anthony deStefano, M.D., Ft. Thomas, Ky. and Cincinnati; University of Cincinnati College of Medicine, 1941; aged 58; died March 30; member of OSMA, AMA, and the American Society of Plastic and Reconstructive Surgery; Fellow, American College of Surgeons; diplomate, American Board of Plastic Surgery; plastic surgeon in Cincinnati and assistant professor at the University of Cincinnati; served in the Navy during World War II.

T. P. Delventhal, M.D., Napoleon; Eclectic Medical College, Cincinnati, 1921; aged 76; died April 15; member of OSMA and AMA; native of Napoleon and practitioner in Henry County for all of his professional career; former Henry County health commissioner and leader in numerous community projects.

Lena Stafford Enright, M.D., Boca Raton, Fla.; Ohio State University College of Medicine, 1934; aged 76; died March 24; member of OSMA, AMA and American Academy of Pediatrics; diplomate, American Board of Pediatrics; retired last November after practicing in Findlay for 33 years, specializing in recent years in pediatrics.

Virginia Margaret Esselborn, M.D., Cincinnati; University of Cincinnati College of Medicine, 1944; aged 64; died April 16; member of OSMA, AMA, and the Endocrine Society; clinical professor of medicine, University of Cincinnati; practicing physician in Cincinnati, specializing in endocrinology.

Donald De Klyn Forward, M.D., Marathon, Fla.; Western Reserve University School of Medicine, 1923; aged 76; died April 8 in Ashtabula; member of OSMA and AMA; general practitioner in Ashtabula from 1925 until his retirement in 1962; veteran of both World Wars I and II.

John Joseph Gallen, M.D., Columbus; Ohio State University College of Medicine, 1933; aged 63; died April 26; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner of long standing in Columbus; veteran of World War II.

John S. Hopping, M.D., formerly of Springfield; Hahnemann Medical College of Philadelphia, 1940; aged 56; died March 29; member of OSMA and AMA; medical director of the Wittenberg University Health Center from 1965 to 1971; recently was residing in Maine.

Clarence F. Murbach, M.D., Archbold; University of Michigan Medical School, 1909; aged 86; died April 11; member of OSMA and AMA; Fellow, American College of Surgeons; practicing physician and surgeon in the Archbold area for some 57 years, and member of a family of physicians; served in the Army Medical Corps during both World Wars I and II. Dr. Edwin R. Murbach, also of Archbold, is a nephew.

Rudolf Jan Nowara, M.D., Canton; University of Tuebingen, West Germany, 1950; aged 49; died March 30; member of OSMA and AMA; came to this country in 1952 and began practice in Canton in 1957, specializing in the ENT field. One son, Dr. Wolfgang Nowara, is a physician now in military service.

Peter P. Ogden, M.D., Barberton; University of Warsaw, Poland, 1927; aged 79; died March 28; member of OSMA and AMA; native of Latvia who came to this country 23 years ago; general practitioner in Barberton for 15 years.

Ralph Morris Patterson, M.D., Columbus; University of Michigan Medical School, 1930; aged 67; died April 4; former member of OSMA and AMA; member of American Psychiatric Association and the Central Neuropsychiatric Association; diplomate, American Board of Psychiatry and Neurology; former chairman of the Department of Psychiatry at OSU; past president, Central Psychiatric Association and the Ohio Psychiatric Association.

Vladas Leonas Ramanauskas, M.D., Cleveland; medical degree from the University at Kaunas, Lithuania, 1944; aged 56; died April 4; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in Cleveland since 1950.

John William Smythe, M.D., Oregon and Toledo; Western Reserve University School of Medicine, 1941; aged 56; died April 14; member of OSMA, AMA, and the Radiological Society of North America; Fellow, American College of Radiology; diplomate, American Board of Radiology; radiologist for a number of years in the Toledo-Oregon area.

Raymond Joseph Stasny, M.D., Cleveland; St. Louis University School of Medicine, 1926; aged 72; died April 10; former member of OSMA; general practitioner of long standing in the Cleveland area.

William S. Thal, M.D., Toledo; University of Michigan Medical School, 1938; aged 57; died April 13; member of OSMA, AMA, American Society of Internal Medicine and American Thoracic Society; Fellow, American College of Physicians; diplomate, American Board of Internal Medicine; native of Toledo and practicing physician there for many years.

Donald Colin Wilson, M.D., Toledo; University of Toronto Faculty of Medicine, 1939; aged 59; died April 13; member of OSMA, AMA, American Diabetes Association and American Society of Clinical Pathologists; diplomate, College of American Pathologists; pathologist in Toledo for a number of years and associated with Riverside Hospital for 17 years.

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

HER NAME IS Eloise Allison — Mrs. H. W. Allison, of Summit county. She has just retired as editor of our outstanding state magazine — the *Ohio Medical Auxiliary News.* For some eight years, Eloise has given her talents, her thoughts, her waking hours (and probably what should have been some sleeping hours!) to Auxiliary News.

She served first as assistant editor (under that "shining light," Ludel Sauvageot) and then moved up to editor five years ago when Ludel — Mrs. J. Paul Sauvageot, also of Summit county — became state president. Today Ludel is editor of *MD's Wife,* the provocative national auxiliary magazine. Eloise says she simply "couldn't miss" with such a terrific teacher those first years!

Inevitably, an editor writes about people other than herself. She features photographs and action pictures of people other than herself. Which, I concede, is as it should be. However, there should come a time — and I think this is the time — to turn the spotlight on that Auxiliary News editor who has served her state auxiliary so well, and place HER on the printed page for a change!

In a sense, this is my own personal tribute to a colleague with whom I have had the privilege of working these past eight years. We shared workshop publicity sessions — we shared news items — we shared ideas — we shared the joys **and** problems of creating images via the printed word — and happily we became good friends. So many times I have watched her in action as she photographed important people and moments for Auxiliary News. She has become a first rate press photographer. Considering Eloise's attractiveness and engaging smile, she should have turned the camera on herself!

No story on our Lady Editor would be complete without mention of the most important part of her life — her family. Dr. Allison practices internal medicine in Akron (and he must have had to practice unlimited patience every time the Auxiliary News deadline rolled around during those eight long years!) There are four daughters: Christine Schwab, married and teaching in Charleston, South Carolina; Mary Ellen who works for the Hunter Foundation in Lexington, Kentucky; Bronwyn who is a senior in art at Ohio State; and Gwynne who will be a high school senior, come September.

Eloise has turned over her blue pencil and camera and other appurtenances to Mrs. S. J. Glueck (Charlotte) and Mrs. Robert Holladay (Lavonne), the new editor and co-editor respectively. Charlotte is from Springfield and Lavonne from Lima.

An affectionate salute to the outgoing editor; a warm and sincere greeting to the incoming editors, with every good wish for a most successful stewardship.

Around the State

The Fourth District meeting was held at the Fremont Country Club and featured a talk by James Imboden of the AMPAC field office in Columbus. Present at the meeting was Mrs. Russel Wiessinger, state president, along with Mrs. Willis Damschroder, district director, and Mrs. Charles Hull, Sandusky County president.

The Fifth District meeting took place on April 20th at the Lantern Court, Holden Arboretum in Mentor. Lantern Court is the former Corning Mansion, and as a special treat, auxiliary members toured this magnificent home. Mrs. Thomas Manning, district director, was in charge of the arrangements and program. There was a showing of fashions purchased abroad and modeled by the doctors' wives. Auxilians attended from Lake, Ashtabula, Geauga and Cuyahoga Counties.

Lilac Luncheon

It was beautiful and spring-like inside Cleveland's Acacia Country Club. The stylized lilac tree in lavender, pink and white that graced the center of each luncheon table resembled a May Pole. Ironically, outside it was winter on that 23rd day of March, cold and with swirling gusts of snow.

But the outside dreariness failed to penetrate the warmth, the enthusiasm, the large turn-out of the Cuyahoga county members and their guests. The social hour at 11:30 a.m. that preceded the luncheon afforded the 350 women present the opportunity to examine the beautiful items offered



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rtant Note: This drug is not a simple analgesic. ot administer casually. Carefully evaluate patients re starting treatment and keep them under close rvision. Obtain a detailed history, and complete ical and laboratory examination (complete ogram, urinalysis, etc.) before prescribing and at ent intervals thereafter. Carefully select patients, ding those responsive to routine measures, con- dicated patients or those who cannot be observed ently. Warn patients not to exceed recommended ge. Short-term relief of severe symptoms with smallest possible dosage is the goal of therapy. ge should be taken with meals or a full glass of . Patients should discontinue the drug and report ediately any sign of: fever, sore throat, oral ns (symptoms of blood dyscrasia); dyspepsia, astric pain, symptoms of anemia, black or tarry ls or other evidence of intestinal ulceration or orrhage, skin reactions, significant weight gain or na. A one-week trial period is adequate. Discon- in the absence of a favorable response. Restrict ment periods to one week in patients over sixty. *cations:* Acute gouty arthritis, rheumatoid arthritis, matoid spondylitis.

traindications: Children 14 years or less; senile ents; history or symptoms of G.I. inflammation or ration including severe, recurrent or persistent epsia; history or presence of drug allergy; blood rasias; renal, hepatic or cardiac dysfunction; rtension; thyroid disease; systemic edema; atitis and salivary gland enlargement due to the ; polymyalgia rheumatica and temporal arteritis; ents receiving other potent chemotherapeutic ts, or long-term anticoagulant therapy.

nings: Age, weight, dosage, duration of therapy, tence of concomitant diseases, and concurrent nt chemotherapy affect incidence of toxic reac- s. Carefully instruct and observe the individual ent, especially the aging (forty years and over) have increased susceptibility to the toxicity of the . Use lowest effective dosage. Weigh initially redictable benefits against potential risk of severe, fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

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Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

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for sale at the silent auction. There were many valuable antiques as well as home decorating pieces. Another table literally glistened with the incredible beaded floral arrangement made by the auxiliary's beading class and on which chances were being taken. Also chanced off were a silved candelabrum, a car stereo tape deck and a ladies' wristwatch. The money raised at the annual Lilac Luncheon is for the auxiliary's Philanthropy Fund.

Following the luncheon, there was a show of fashions in the spring mood by Rae Phillips of Cleveland, with doctors' wives serving as models. A message of welcome was given by Mrs. Paul Chrenka, Cuyahoga president, who introduced Mrs. Russell Wiessinger, state auxiliary president.

The "Lilac Time" committee was headed by Mrs. A. J. Fanta, chairman and Mrs. Abdul F. Naji, cochairman (Mrs. Naji designed the invitations and posters). Mrs. Chet Lulenski served as decorations and invitation chairman; Mrs. Franklin Simicek and Mrs. Javier Lopez were chairmen of reservations; Mrs. Eugene Chandler, chairman of the Silent Auction; Mrs. Lambert DePompei, chairman of the General Raffle; Mrs. David Mendelsohn, Jr., public relations and coordinator for the style show; and Mrs. Paul J. Sindelar, chairman of hostesses. Mrs. Thomas L. Manning, Fifth District director, was the accomplished piano accompanist for the style show. Mrs. Christopher Colombi served as honorary chairman by virtue of her sponsorship of the luncheon at the Acacia Country Club (I think we should make mention of Dr. Colombi too, since he is an important part of the Colombi "team" and Country Club membership!)

Creative Women

"Creative Women" was the title of the combined salad smorgasbord and meeting of the **Franklin County** auxiliary and the Columbus Dental Society auxiliary at a recent meeting at the Covenant Presbyterian Church. Speakers were Mrs. Edward Miller who discussed topics of contemporary spinning and fabric weaving and Mrs. Richard Smythe who spoke on the art of weaving Rya rugs. Auxiliary members brought samples of their own creation for display. Gourmet soups were provided by the "gourmet group" while other members brought a favorite salad.

Crafts on display included textile arts, needlework, stitchery, needlepoint, weaving, hooking, sewing, knitting, crocheting, macrame, jewelry, metal, woodworking, glass, enameling, and ceramics sculpture. The afternoon program was arranged by Mrs. Carl Coleman and Mrs. James Best. Hostesses were Mrs. William Inglis, Mrs. Howard

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Lowery and Mrs. Clarence Maxwell. Mrs. Patrick Creedon and Mrs. Charles Pavey served as chairman of the Gourmet food.

Rabbi Folkman

Rabbi Jerome D. Folkman is a favorite guest speaker of Ohio doctors' wives! He has discussed "The Medical Family" at state conventions and before local auxiliary groups. His perception of the special problems of doctors' families and his solid advice on ways to solve these problems were again demonstrated when he spoke before the **Hamilton** and **Butler** auxiliaries on April 18 at the Crest Hills Country Club. The luncheon meeting was a joint undertaking of the two groups.

Dr. Folkman holds a doctor of philosophy degree and is the Rabbi at Temple Israel in Columbus. He is also Adjunct Professor of Sociology at Ohio State, specializing in family living.

The April 18 Hamilton-Butler festivity had as its chairmen: Mrs. Ralph Miller, program; Mrs. Alfred S. Gardiner, chairman of the day; Mrs. Fawzy S. Mansour, decorations and hostesses. Mrs. Charles Blase presided at her last meeting as president of the Hamilton group. Mrs. C. Donald Stevens, president of the Butler auxiliary shared honors with Mrs. Blase.

Installation of Hamilton county officers for 1972-73 also took place on that day. Mrs. Russell Wiessinger, state president, administered the oath of office to the incoming officers (installation was a bit earlier this year because of the state convention in Cincinnati May 8-11). The new governing body includes: Mrs. Emil Barrows, president; Mrs. Richard Wurzelbacher, president-elect; Mrs. Richard Wendel, vice-president; Mrs. Richard Neubauer, recording secretary; Mrs. Victor Hinrichs, corresponding secretary; and Mrs. Robert Niehaus, treasurer.

Hamilton County had a fund-raising Fashion Show on March 21 at the Beverly Hills Supper Club. Exciting fashions from Gidding-Jenny of Cincinnati highlighted the annual fashion show luncheon. The models were doctors' wives, but of course! Mrs. Denis Cash served as chairman of this event that attracted some 500 women and helped raise close to $1,000. *The Cincinnati Post* ran a feature article on the fashion show and its chairman. Mrs. Cash is an expert on "wok" — and what she calls her "family Chinese." Interest in wok cooking began after Dr. and Mrs. Cash made a trip to San Francisco and made the rounds of all the Oriental restaurants.

Mrs. Robert Krone of our State Board has written a two-article series on "The Land of Contrasts" that also appeared in the columns of the *Cincinnati Post* in March. The articles are based on Fran's February trip to Africa. I hope to use some of that material in the not-too-distant future. It's terrific!

Other Counties

The **Licking County** auxiliary celebrated its 25th anniversary in March. The historical Buckingham House was the setting for the Anniversary Tea. A summary of the history of the local group was presented, highlighting the major project of nurse scholarships. Thirty such scholarships have been given, with 21 young women becoming R.N.'s. The Auxiliary also handles the finances for the scholarships given by the Licking County Medical Society that have helped 22 girls, of which 14 have become registered nurses.

Other community projects reviewed at the birthday celebration included contributions to AMA-ERF, help with the annual Heart Fund Tea, work with the local cancer society (showing an educational cancer film to high school students) and driving people to the polls at election time. In the early years, there were many money making projects such as rummage and bake sales, saving tax stamps and Tupperware and knife sales.

Today the auxiliary holds monthly dinner meetings in the homes of members, charging for the meals. Returns financially have been adequate enough to allow the group to dispense with other fund-raising projects. An honored guest at the Anniversary Tea was Mrs. Russell L. Wiessinger, state president, who joined the group for an afternoon of fellowship and reminiscing.

Lucas County sure lands the "big ones"! On April 11, the Auxiliary Invitational Dessert and General Meeting had as the featured speaker Mrs. George Romney who discussed "The Role of Women in Our World Today." I'm hoping that I can coax out of Lucas more detailed information on this meeting and the remarks of Mrs. Romney because I feel that what she had to say will well bear repeating in this column.

The annual luncheon honoring the Citizens Day Care Center Volunteers was held on May 1 at the home of the luncheon chairman, Mrs. R. E. Scherbarth. Mrs. A. J. Kuehn was honored for her many years of service to younger school age children.

At its annual Bridge Luncheon in March, the Lucas auxiliary concentrated on raising money for AMA-ERF. Along with the proceeds from the social event, AMA-ERF benefitted from the sale of a new kind of umbrella. It is described as "chic, self-opening and slim tailored," and comes in six different colors (one for each of milady's

costumes?) and has a crook handle and matching alligator case. It is guaranteed for two years against defective material or workmanship and the cost is surprisingly modest — $5. Any umbrellas left, Lucas?

Another "25"

The **Ottawa County** group has just celebrated its 25th anniversary. In a fine feature story in the *Port Clinton Herald,* the many accomplishments of the local auxiliary were detailed. They ranged from its first project of raising funds for the (then) future wing of the H. B. Magruder Memorial Hospital to the purchase of an autopsy table, the furnishing of the autopsy room, picnics for hospital personnel, teas for students interested in Nursing, tray favors for hospital patients, distribution to schools of health education material, Mobile Meals program and other related health activities. A recent project has to do with the special plaque honoring all the doctors who have been on the staff of Magruder Hospital since it opened its doors. Compilation of the list took two years under the diligent direction of Mrs. James I. Rhiel and Mrs. C. R. Wood.

Still Other Doin's

At a recent meeting of the **Trumbull** auxiliary, two members — Mrs. C. M. Venetta and Mrs. J. S. Schlecht — were honored in recognition of their work with the Mobile Meals program. Brunch was served by the hostess, Mrs. Thomas E. Wilson. Mrs. K. P. Swisterski, president, conducted the business meeting which included approval of the 1972 budget, choosing a nominating committee and election of new officers. Then the group moved from the Wilson home to the Trumbull County Children's Home for a conducted tour and a briefing by members of the administrative staff on the different activities and services.

Nine charitable organizations involved in some line of health or medical service were the recipients recently of an annual contribution from the Trumbull auxiliary. This is made possible by the group's traditional Spring Dance — the only money-making project of the local doctors' wives. Here is a fine example of a community-oriented project.

* * * *

"Ring Out The Old, Ring In The New" — auxiliary year! It just doesn't seem possible . . .

Continuing Education Opportunities for Physicians in Ohio

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

June

Symposium on Microneurosurgery — Departments of Neurosurgery, Good Samaritan and Christ Hospitals, Cincinnati, June 8-10; distinguished guest and local faculty; Contact Dr. John M. Tew, Jr., 506 Oak Street, Cincinnati 45219.

Anxiety Reactions and Their Management — St. Elizabeth Hospital, Youngstown; June 9, 8:00-9:00 a.m.; Dr. F. Gelbman.

Modern Concepts in Clinical Cardiology — An American College of Physicians postgraduate course; University of Cincinnati College of Medicine, June 12-16; director, Noble O. Fowler, M.D.; codirector, Robert J. Adolph, M.D.

Management of Hypertension — St. Elizabeth Hospital, Youngstown; June 16, 8:00-9:00 a.m.; Dr. W. Bunn.

Drug Induced Thrombocytopenia and Hemolytic Anemia — Youngstown Hospital Association, South Unit, June 19; Drs. L. M. Pass and N. A. Pappas.

Worms and Man — St. Elizabeth Hospital, Youngstown, June 23, 8:00-9:00 a.m.; Drs. G. Canatsey and P. Van Zandt.

July

Fourth Annual Ohio State Urologic Outing—Subject, "Urologic Infections"; at Avon Inn, Warren, July 31-August 2; contact Chester C. Winter, M.D., Room N—809, University Hospital, Columbus 43210.

August

Fifth Postgraduate Institute for Physicians on Sports Medicine — Sponsored by OSMA, Ohio High School Athletic Association, and the OSU College of Medicine, August 2-3 at the Center for Tomorrow, 2400 Olentangy River Road, Columbus. Contact Center for Continuing Medical Education at Ohio State; registration fee, $30.

Third Annual Short Course on Laser Safety —Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, at the University, August 7-11; tuition, $325. Contact course director, Mr. R. James Rockwell, Jr., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229.

Annual Scientific Assembly, Ohio Academy of Family Physicians—Sheraton-Columbus Hotel, downtown Columbus, August 8-10.

Officers and AMA Delegates Elected at the 1972 Annual Meeting

DR. WILLIAM R. SCHULTZ, of Wooster, was installed as President of the Ohio State Medical Association at the final session of the House of Delegates in Cincinnati on May 11. He was named President-Elect at the 1971 Annual Meeting in Columbus after serving six years as Councilor of the Eleventh District.

Dr. Oscar W. Clarke, Gallipolis, was named President-Elect and will succeed to the Presidency at the 1973 Annual Meeting to be held in Columbus. Dr. Clarke has served from 1966 to the current year on The Council as Councilor of the Ninth District.

The House of Delegates also named four new Councilors and reelected two for additional two year terms.

Dr. Stephen P. Hogg, Cincinnati, was elected Councilor of the First District to succeed Dr. Paul N. Ivins, of Hamilton, who had served the maximum of three full terms on The Council.

Dr. John C. Smithson, of Findlay, was elected Councilor of the Third District to succeed Dr. Dwight L. Becker, of Lima, who has served two terms on The Council and was not a candidate for reelection.

Dr. Robert E. Rinderknecht, Dover, was elected Councilor of the Seventh District to succeed Dr. Sanford Press, of Steubenville, who had served the maximum time on The Council.

Dr. Thomas W. Morgan, Gallipolis, was named Councilor of the Ninth District to succeed Dr. Clarke, the new President-Elect.

Dr. David Fishman, Cleveland, was reelected Councilor of the Fifth District.

Dr. Robert G. Thomas, Elyria, was reelected Councilor of the Eleventh District.

Dr. P. John Robechek, Cleveland, as Immediate Past President of the Association, will serve an additional year on The Council.

Councilors in the midst of two year terms are the following: Dr. James G. Tye, Dayton, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Maurice F. Lieber, Canton, Sixth District; Dr. William M. Wells, Newark, Eighth District; and Dr. James C. McLarnan, Mt. Vernon, Tenth District.

Dr. James L. Henry, Grove City, is serving his second term as Secretary-Treasurer.

The House of Delegates reelected the following Delegates to the American Medical Association for additional two-year terms beginning January 1, 1973: Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Oberlin; Dr. Robert N. Smith, Toledo; and Dr. Robert E. Tschantz, Canton.

Reelected Alternate Delegates to the AMA for two-year terms beginning January 1, 1973 were the following: Dr. Dwight L. Becker, Lima; Dr. David Fishman, Cleveland; Dr. Robert P. Johnson, Middletown; and Dr. H. William Porterfield, Columbus.

Hold-over Delegates are Dr. Oscar W. Clarke, Gallipolis; Dr. Henry A. Crawford, Cleveland; Dr. Harry K. Hines, Cincinnati; Dr. Frederick P. Osgood, Toledo; and Dr. P. John Robechek, Cleveland.

Hold-over Alternate Delegates to the AMA are Dr. George N. Bates, Toledo; Dr. Richard L. Fulton, Columbus; Dr. Jerry L. Hammon, West Milton; Dr. William J. Lewis, Jr., Dayton; and Dr. Jack Schreiber, Canfield.

Because of the time element involved, only this brief summary of election results could be included in this issue of *The Journal.* Watch for the July number and complete reports of the 1972 Annual Meeting, including official minutes of the House of Delegates.

County Societies' Officers and Meeting Dates

ROSTER UPDATED THROUGH MAY 15, 1972

First District

Councilor: Stephen P. Hogg, Cincinnati 45219
250 Wm. Howard Taft Rd.

ADAMS—Beverly B. Lafferty, President, 107 Wilson Dr., West Union 45693; Hazel L. Sproull, Secretary, 113 E. Mulberry St., West Union 45693. 1st Tuesday of Jan., April, July, and Oct.

BROWN—John R. Donohoo, President, 111 W. Cherry St., Georgetown 45121; Antonio P. Mendoza, Secretary, 120 E. Plane St., Bethel 45106.

BUTLER—Gordon F. Smith, President, 105 Old St., Monroe 45050; Mr. E. Clifford Roberts, Executive Secretary, 111 Buckeye St., Hamilton 45011. 4th Wednesday.

CLERMONT—Richard K. Lancaster, President, 684 Cincinnati-Batavia Pike, Cincinnati 45245; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103. 3rd Wednesday, except July, Aug., and Dec.

CLINTON—Edwin F. Bath, President, 240 W. Main St., Wilmington 45177; Edmond K. Yantes, Secretary, 168 W. Main St., Wilmington 45177. 4th Tuesday.

HAMILTON—Milton W. Gwinner, President, 2981 Madison Rd., Cincinnati 45209; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 2nd Tuesday, Sept., Nov., Jan., Feb., April, and May.

HIGHLAND—Walter Felson, Acting Secretary, 357 South St., Greenfield 45123.

WARREN—Gilbert K. Ohlhauser, President, 309 Reading Road, Mason 45040; Orville L. Layman, Secretary, 22 W. Fourth St., Franklin 45005. 2nd Tuesday at Golden Lamb Inn, Lebanon.

Second District

Councilor: James G. Tye, Dayton 45402
I.B.M. Building, Suite 520

CHAMPAIGN—Terrence F. Grogan, President, 848 Scioto St., Urbana 43078; John Flora, Secretary, 848 Scioto St., Urbana 43078. 2nd Wednesday.

CLARK—John Summers, President, 444 W. Harding Rd., Springfield 45504; Mrs. Marion L. Wilcoxson, Executive Secretary 616 Bldg., Room 131, 616 N. Limestone St., Springfield 45503. 3rd Monday.

DARKE—Thomas P. Chase, President, Ansonia Medical Center, Ansonia 45303; J. R. Solis, Secretary, Wayne Hospital, Greenville 45331. 3rd Tuesday.

GREENE—Antonio Mannarino, President, Green Memorial Hospital, N. Monroe Dr., Xenia 45385; Mrs. W. F. (Miriam) Whitt, Executive Secretary, 966 Whitestone Rd., Xenia 45385. 3rd Thursday.

MIAMI—William N. Adkins, President, 216 Penn Rd., Troy 45373; A. Robert Davies, Secretary, 57 Robinhood Lane, Troy 45373. 1st Tuesday.

MONTGOMERY—Russell N. Brown, President, 1126 S. Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Bldg., Dayton 45402. Monthly as established by Executive Council.

PREBLE—J. D. Darrow, President, 228 N. Barron St., Eaton 45320; J. R. Williams, Secretary, 228 N. Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 S. Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 S. Main Ave., Sidney 45365. 2nd Tuesday, March, June, Sep., and Dec.

Third District

Councilor: John C. Smithson, Findlay 45840
521 W. Sandusky St.

ALLEN—David A. Barr, President, 825 W. Market St., Lima 45804; Mr. Waldo Smith, Executive Secretary, Box 803, Lima 45801. 3rd Tuesday.

AUGLAIZE—Dale Kile, President, 112 Court St., St. Marys 45885; Charles Stienecker, Secretary 1007 W. Auglaize St., Wapakoneta 45895. 1st Thursday every odd month, starting with January.

CRAWFORD—V. Allen Auchard, President, 130 Hill St., Bucyrus 44820; John Kurtz, Secretary, 139 Gaius St., Bucyrus 44820. Called monthly meetings 4 to 5 times per year.

HANCOCK—Charles R. Blake, President, 1920 S. Main St., Findlay 45840; Truman S. Smith, Secretary, 145 W. Wallace St., Findlay 45840. 3rd Tuesday, except July and Aug.

HARDIN—John H. Hughes, President, R.R. #1, Kenton 43326; Larry Clark, Secretary, 331 Koehler St., Kenton 43326. 2nd Tuesday.

LOGAN—Douglas W. Beach, President, 1008 N. Main St., Bellefontaine 43311; Arnaldo R. Roldan, Secretary, Huntsville 43324. 1st Friday.

MARION—James Schuler, President, 399 E. Church St., Marion 43302; Raymundo Concepcion, Secretary, 1040 Delaware Ave., Marion 43302. 1st Tuesday, except June, July, Aug., and Oct.

MERCER—Louis J. Finkelmeier, President, 111 N. Walnut, Celina 45822; R. Duane Bradrick, Secretary, Box 145, Rockford 45882. 3rd Thursday.

SENECA—Donald W. Shanabrook, President, 455 W. Market St., Tiffin 44883; Roberto R. Pagarigan, Secretary, 40 Clay St., Tiffin 44883. 3rd Tuesday.

VAN WERT—H. C. Smith, President, Medical Arts Bldg., Van Wert 45891; N. L. Marxen, Secretary, Medical Arts Bldg., Van Wert 45891. Quarterly.

WYANDOT—K. K. Solacoff, President, 777 N. Sandusky Ave., Upper Sandusky 43351; Joseph J. Browne, Secretary, 777 N. Sandusky Ave., Upper Sandusky, 43351. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Nicolas E. Balmoria, President, 1206 E. Second St., Defiance 43512; Miss Lois Coffin, Executive Secretary, Defiance Hospital, P.O. Box 386, Defiance 43512. 1st Saturday.

FULTON—Richard L. Davis, President, 137 S. Fulton St., Wauseon 43567; Gerald A. Perkins, Secretary, R.R. #1, Box 20-A, Delta 43515. Quarterly.

HENRY—

LUCAS—Theron L. Hopple, President, 1056 Secor Hotel, Rm 1006, Toledo 43603; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Ave., Toledo 43610. 4th Tuesday.

OTTAWA—Donald L. Loeffler, President, 521 E. Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P.O. Box J. Port Clinton 43452. 2nd Thursday.

PAULDING—Walter Bazali, President, E. River St., Antwerp 45813; Paul Ward, Secretary, Box 416, Oakwood 45873. 3rd Monday.

PUTNAM—James Overmier, President, 109 Main St., Leipsic 45856; Arthur P. Daniel, Secretary, 144 N. Walnut St., Ottawa 45875. 3rd Monday.

SANDUSKY—W. W. Randolph, Jr., President, Memorial Hospital, Fremont 43420; Mrs. Patsy Askins, Executive Secretary, Memorial Hospital, Fremont 43420. 3rd Wednesday (four meetings per year).

WILLIAMS—Shelby O. Cooper, President, Bryan Medical Group, Inc., Central Ave., Bryan 43506; Robert A. Prots, Secretary, Bryan Medical Group, Inc., Central Ave., Bryan 43506. 3rd Tuesday.

WOOD—Vytautas V. Urba, President, 1010 N. Prospect St., Bowling Green 43402; Restituto H. Alonzo, Secretary, 725 Haskins Rd., Bowling Green 43402. 3rd Thursday.

Fifth District

Councilor: David Fishman, Cleveland 44106
10515 Carnegie Avenue

ASHTABULA—Richard S. Millberg, President, 430 West 25th St., Ashtabula 44004; Mrs. Marilyn Mathews, Executive Secretary, P.O. Box 1772, Ashtabula 44004. 2nd Tuesday.

CUYAHOGA—Joseph L. Bilton, President, 3070 Mayfield Rd., Cleveland 44118; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. 2nd Tuesday.

GEAUGA—Adrian Krudy, President, P.O. Box 249, Chardon 44024; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Thursday.

LAKE—Albert M. Bringardner, President, 89 E. High St., Painesville 44077; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060. 4th Wednesday evening of Jan. March, May, Sept., and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St. N.W.

COLUMBIANA—Stephen Sinclair, President, 205 W. 6th St., East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday.

MAHONING—Henry Holden, President, 932 Belmont Ave., Youngstown 44504; Mr. Howard Rempes, Executive Secretary, 1005 Belmont Ave., Youngstown 44504. 2nd Tuesday of Jan., March, May, Sept., Nov., and Dec.

PORTAGE—A. A. Kuri, President, 250 S. Chestnut St., Ravenna 44266; Mrs. Phoebe Leach, Executive Secretary, 449 S. Meridian St., Ravenna 44266. 3rd Tuesday.

STARK—Wm. A. McCrea, President, 311 E. State St., Alliance 44601; Mr. John H. Austin, Executive Secretary, 405 4th St., N.W., Canton 44702.

SUMMIT—Richard H. Champion, President, 513 W. Market St., Akron 44303; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant St., Akron 44311.

TRUMBULL—Theodore A. Russell, President, 200 Garfield Dr., Warren 44483; Mrs. Kay Ticknor, Executive Secretary, 280 N. Park Ave., Warren 44481. 3rd Wednesday, Sept. through May.

Seventh District

Councilor: Robert E. Rinderknecht, Dover 44622
404 N. Walnut St.

BELMONT—German Ortiz, President, R.D. #2, Route 250, Dillonvale 43917; Bertha M. Joseph, Secretary, 100 S. 4th St., Martins Ferry 43935. 3rd Thursdays of Feb., March, April, June, Sept., Oct., Nov., and Dec.

CARROLL—Glenn C. Dowell, President, 207 W. Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 S. Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—J. Clifford Briner, President, 105 N. Kirk St., West Lafayette 43845; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday except July and Aug.

HARRISON—Gerald E. Vorhies, President, Scio 43988; James Z. Scott, Secretary, Box 512, Scio 43988. Quarterly.

JEFFERSON—Jonathan J. Yobbagy, President, St. John Hospital, Steubenville 43952; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug., and Dec.

MONROE—

TUSCARAWAS—Ghana S. Tripathy, President, 119 Second St. N.E., New Philadelphia 44663; Benjamin Wherley, Secretary, Boulevard Medical Bldg. Dover 44662. 3rd Wednesday.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson Street

ATHENS—Charles S. Baldwin, President, Box 359, Nelsonville 45764; L. A. Hamilton, Secretary, 400 E. State St., Athens 45701. 2nd Tuesday, March, June, Sept., and Dec.

FAIRFIELD—Anna Whetstone, President, Millersport 43046; David H. Sheidler, Secretary, 1500 E. Main St., Lancaster 43130. 2nd Tuesday.

GUERNSEY—Q. F. Knauer, President, 100 Clark St., Cambridge 43725; Robert O. Thiele, Secretary, Box #37, Byesville 43723. 1st Tuesday.

LICKING—Irving A. Nickerson, President, Granville Medical Center, Weaver Dr., Granville 43023; John R. Pollack, Secretary, 1320 W. Main St., Newark, 43055. 4th Tuesday except June, July and Aug.

(Eighth District—*Continued*)

MORGAN—A. H. Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM—Charles R. Donley, President, 2762 Bell, Zanesville 43701; Hudnall J. Lewis, Secretary, 515 Taylor, Zanesville 43701.

NOBLE—Frederick M. Cox, President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, Secretary, P.O. Box 239, Caldwell 43724. 1st Tuesday.

PERRY—George C. Tedrow, President, Crooksville 43731; Charles B. McDougal, Secretary, Courthouse, New Lexington 43764.

WASHINGTON—Donald E. Fleming, President, Vincent 45784; Tuathal P. O'Maille, Secretary, 426 Fourth St. Marietta 45750. 2nd Wednesday, except June, July, and Aug.

Ninth District

Councilor: Thomas W. Morgan, Gallipolis 45631
1st Ave. and Cedar St.

GALLIA—Donald E. O'Rourke, President, Holzer Medical Center Clinic, Gallipolis 45631; Donald M. Thaler, Secretary, Holzer Medical Center Clinic, Gallipolis 45631. Quarterly.

HOCKING—

JACKSON—Carl J. Greever, President 35 Vaughn St., Jackson 45640; A. R. Hambrick, Secretary, 16 N. Ohio Ave., Wellston 45692. Meetings as called by the President.

LAWRENCE—Gerard C. Geswein, President, 1626 S. Sixth St., Ironton 45638; George N. Spears, Secretary, 2213 S. Ninth St., Ironton 45638. Quarterly.

MEIGS—Joseph J. Davis, President, 306 N. Second Ave., Middleport 45760; Edmund Butrimas, Secretary, 204 E. Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 E. North St., Waverly 45690; Albert Shrader, Secretary, 196 Emmitt St. Waverly 45690. 1st Tuesday.

SCIOTO—Howard E. Baughman, President, 1735 27th St., Portsmouth 45662; Mr. Lowell E. Thompson, Executive Secretary, Scioto County Medical Society, P.O. Box 1348, Portsmouth 45662. 2nd Tuesday.

VINTON—

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—David W. Nardin, President, 43 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Main St. Magnetic Springs 43036. 3rd Tuesday, except June, July and Aug.

FAYETTE—J. H. Persinger, President, 225 E. Market St., Washington, C. H. 43160; M. H. Roszmann, Secretary, 1005 E. Temple St., Washington C. H. 43160. 2nd Friday.

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630 River Street

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RICHLAND—Charles B. Phillips, President, 271 Cline Ave., Mansfield 44907; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903. 3rd Thursday, except June, July, and Aug.

WAYNE—Robert E. Schulz, President, 1761 Beall Ave., Wooster 44691; Thomas M. Graves, Secretary 1740 Cleveland Rd. Wooster 44691. 2nd Wednesday every other month.

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JOURNAL ADVERTISERS

Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products. and let them know that you see their advertisting in *The Journal*.

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Rates: 50 cents per line. Minimum charge $1.00 for each insertion. Display classified, $1.00 per line. (9 lines to the inch) Prices cover the cost of remailing answers. Forms close the 8th of the month preceding publication. To assure prompt delivery, when replying to an advertisement over a *Journal* box number, address letters as follows:

Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

OHIO, FAIRFIELD, Space available in modern Medical Building, 15 miles from Cincinnati. General Practitioner and Specialist needed. Reply to Box 616, c/o The Ohio State Medical Journal.

FAMILY PRACTICE RESIDENCY — Just approved — openings at all levels — can start immediately — for details contact: A. J. Pultz, M.D., Chairman, Family Practice Committee, Grant Hospital, 309 E. State, Columbus, Ohio 43215.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

MODERN OFFICE available in Medical Building in Ashland, Ohio. 5 Doctors and a Pharmacy. Population 20,000 and good hospital facilities. Reply Box 643, c/o The Ohio State Medical Journal.

G.P. OR INTERNIST — To join medical staff of institution for mentally retarded near Columbus on contract basis. 40 hour week. Salary and hours negotiable. Full or part time. Reply: Jerry Maloon, M.D., Chief of Staff, or Robert L. Frazier, M.D., Superintendent, Orient State Institute, Orient Ohio 43146. Telephone 614-877-4314.

IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

A PRIME OPPORTUNITY — For a General Practitioner in a northwestern Ohio community. New medical building available including an X-ray room and lab. Three modern hospitals within 15 to 20 miles. Complete information relative to this opportunity may be obtained by writing, Ottoville Development Corporation. Box 11, Ottoville, Ohio 45876 or phone 419-453-3610 or 419-453-3756 or 419-453-3120.

CIRCLEVILLE, OHIO — 25 miles south of Columbus. Needs physicians, especially General Practice. Population — area of 40,000. New hospital in planning stages. Contact Pickaway County Medical Society, c/o Administrator, Berger Hospital, Circleville, Ohio.

IMMEDIATE OPENING for Internists, Board Certified or Eligible to join five man multi-specialty group in Northeast Ohio. Growing family practice requires two or three new Internists. Excellent location on Lake Erie. New Group Practice Building with lab, X-ray, and physiotherapy facilities. Salary and bonus first two years and full membership thereafter. No initial investment. Good school system, 240 Bed Hospital. Glenn Eippert, M.D., P.O. Box 99, Ashtabula, Ohio 44004.

PSYCHIATRIST OR PHYSICIAN WITH PSYCHIATRIC EXPERIENCE NEEDED FOR FULLY ACCREDITED 1000 BED ADULT PSYCHIATRIC HOSPITAL LOCATED ½ HR. DRIVE FROM CLEVELAND OR AKRON, OHIO. OHIO MEDICAL LICENSE NECESSARY, RECENT ATTRACTIVE INCREASES IN SALARIES AND FRINGE BENEFITS. Call (216) 467-5663 or write Eliere J. Tolan, M.D., Superintendent, Hawthornden State Hospital — Box 305 — Northfield, Ohio 44067.

GENERAL PRACTICE rural community of 5000 serving a medical population of 20,000 plus. 50 bed acute hospital and new 68 bed E.C.F. First year guarantee plus furnished office considered. Call collect Charles H. Bair, Adm. Greenfield Municipal Hospital, Greenfield, Ohio 1-513-981-2116 day or 1-513-780-3107 night. Non discrimination in employment.

WANTED: LOCUM TENENS for E.R. for 1-2-3 months in July, August or September. $3,000 plus my own house per month. Opportunity to join group as fifth man is open! Contact: B. Sarihan, M.D., 2501 Marinette Dr., Springfield, O. 45503, Tel: 513-399-7828.

HOUSE PHYSICIANS Medical and Surgical ECFMG Certificate required. Board Eligibility desirable. Salary commensurate with training and experience. Fringe benefits include paid hospitalization, uniforms, meals, malpractice insurance. Contact: Dept. of Medical Education, 14519 Detroit Road, Lakewood, Ohio 44107.

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(Continued from Previous Page)

POSITIONS OPEN: Ohio Department of Mental Hygiene and Correction.

ASSISTANT COMMISSIONER. The psychiatrist chosen for this position must be able to accept program responsibilities as assigned to him by the Commissioner of Mental Hygiene. This includes overall responsibility for a number of state hospitals ranging from small intensive-care facilities to large extended-care hospitals. He also will be required to help develop a growing statewide community mental health program. Individual selected must be a proven leader and mental hospital executive. Salary open.

* * * *

ASSISTANT COMMISSIONER, BUREAU OF DRUG ABUSE. Ohio's drug abuse program, less than two years old, is in need of further expansion and development. This is to take place at the community level, with the Bureau providing a consultative, funding, coordinating role. With the guidance of the Assistant Commissioner and his professional staff, communities will be helped in developing the necessary array of supportive counseling, rehabilitation, and residential services for a full-range program. Obviously this calls for ability, knowledge, experience, and diplomacy. Physician preferred. Salary open.

* * * *

SUPERINTENDENT, DAYTON CHILDREN'S PSYCHIATRIC HOSPITAL. This position calls for an unusual psychiatrist-leader who can supervise three separate but integrated programs: that of the 96-bed hospital; the Child Guidance Center of Dayton and Montgomery County, which is housed at the hospital; and a residency training program in child psychiatry. Candidates must be board eligible in child psychiatry. Salary open.

* * * *

For any of the above positions, contact: Dr. Gordon F. Ogram, Assistant Commissioner, Div. of Mental Hygiene, Ohio Department of Mental Hygiene and Correction, 1210 Ohio Departments Building, Columbus, Ohio 43215. (614) 469-3806.

SUPERINTENDENT, BROADVIEW CENTER FOR THE RETARDED, a facility of the Division of Mental Retardation. Broadview Center is unique in that it has been developed as a regional center serving the Cleveland-Cuyahoga County area. The Center is located in suburban Brecksville. Among its services are diagnosis and evaluation, short-term in-patient care for up to 150 patients, 24-hour emergency care, and an active outpatient department. The person chosen must be board eligible in an applicable medical specialty. Salary open. Contact: Dr. Roger M. Gove, Commissioner, Div. of Mental Retardation, Ohio Department of Mental Hygiene and Correction, 1209 Ohio Departments Building, Columbus, Ohio 43215. (614) 469-3813.

FOR RENT: Modern, well equipped office space available now in Newark near new hospital, adaptable to General Practice, Pediatrics or Internal Medicine. Write: James H. Johnson, M.D., 604 S. 30th St., Newark, Ohio 43055.

WANTED—General Practitioners. Are you tired of the rat race? There is a great need for your skills in the modern day Mental Health field. Please consider working at a swinging Mental Health Center in Southeastern Ohio in an active college town. For a licensed GP the minimum starting salary would be $20,592 plus additional pay for any overtime above the usual 40 hour work week. Fringe benefits include 2 weeks vacation after 1 year duty, accumulation of sick-leave time, a 50-50 pay basis for Comprehensive Medical Insurance coverage and paid Life Insurance on a graduated scale after 1 year service. Many opportunities for continuing education and for advancement. Generous meeting and travel time. NO OVERHEAD. If at this point you need further information, write: Superintendent, Athens Mental Health Center, Athens, Ohio 45701.

WANTED — Psychiatrists to join a staff of a progressive and active Mental Health Center with heavy emphasis on Community Services but with a crying need to improve the services for those patients who must remain behind. Starting salary range for a board eligible psychiatrist would go from $23,338-$26,312 depending upon background. Fringe benefits include 2 weeks vacation after 1 year duty, accumulation of sick-leave time, a 50-50 pay basis for Comprehensive Medical Insurance coverage and paid Life Insurance on a graduated scale after 1 year service. Many opportunities for continuing education and for advancement. Generous meeting and travel time. NO OVERHEAD. If at this point you need further information, write: Superintendent, Athens Mental Health Center, Athens, Ohio 45701.

WE ARE IN NEED OF PHYSICIANS to run emergency room in S.E. Ohio hospital. Dr. needed who can adjust to local situation including outpatient care. Salary $25,000 per year. Terms and details may be discussed. Contact Dave H. Leasure, Jr., Administrator, Lawrence County General Hospital, Ironton, Ohio 45638. Phone 614-532-3231.

GENERAL PRACTITIONER WANTED: Age up to 54 as equal partner without investment in my very busy general practice. Your income $65-70,000 with opening of my new branch office, air conditioned, ultra modern building starting within weeks income for 2 doctors will extend to $100,000 yearly. No O.B. Population of city, above six hundred thousand. Reply Box 650, c/o Ohio State Medical Journal. Foreign graduates welcomed. Ohio license necessary.

EXCELLENT OTOLARYNGOLOGY PRACTICE available October, 1972, in Lakewood, Ohio. Doctor retiring. Ideal layout with three examining rooms in modern one-story medical building. Furniture and equipment excellent. Good parking. Lease-rental very fair. Three large modern hospitals nearby. Contact: Dr. George W. Metz, 15700 Madison Ave., Lakewood, O. 44107.

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M.D. GRADUATE OF OHIO STATE UNIVERSITY COLLEGE OF MEDICINE, interested in general practice, emergency room service or anesthesiology, or a combination of above areas of medical practice, no Obstetrics. Reply: Box 636 c/o Ohio State Medical Journal.

PSYCHIATRIC STAFF—Requirements of 3 year residency training to Board Certified. $26,000 to $36,300 depending on qualifications and experience. Excellent Michigan Civil Service fringe benefits. Smog free, peaceful, cultural, summer-winter vacationland community. College town. Near Interlochen National Music Camp. 1400 bed progressive psychiatric hospital. J.C.A.H. approved. 3 year psychiatric residency program. Contact M. Duane Sommerness, M.D., Room 324 Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

FREEDOM, HAPPINESS, AND CHALLENGE!!! Since you are reading this, you are probably dissatisfied with long hours, no free time for family or hobbies, cost of living, and/or your local community problems. We are looking for a skilled general practitioner under 55 to join our 40-bed JCAH-accredited hospital and outpatient clinic. Manhattan is a town of 30,000 friendly people located in the beautiful, rolling Flint Hills with two large lakes, cultural attractions you wouldn't believe, recreation and sporting opportunities aplenty, regular 8-5, minimum call 3-4 nights per month, salary of $24,000, one-month paid vacation. But more important, we offer freedom and happiness in a healthy and beautiful environment. It only costs 10¢ for more information since we can't tell you everything in this ad. R. E. Sinclair, M.D., University Hospital, Kansas State University, Manhattan, KS 66502.

GENERAL SURGEON & FAMILY PHYSICIAN: 2 men to provide health services in new community financed hospital in Jennings County, Indiana. No other hospital in county of 22,000. Three other general practitioners in county. New hospital equipped to provide many health services. Hospital Board will contract with the physicians for services. For further details, call Cory SerVaas, M.D., (317) 634-1100.

OPHTHALMOLOGIST — Young, board certified ophthalmologist seeks another young man to associate in a large, rapidly growing medical and surgical practice. Warren, Ohio is a dynamic community with many opportunities and easily accessible to Cleveland and Pittsburgh. If interested, please contact R. D. Shapiro, M.D., 3893 E. Market St., Warren, Ohio 44484.

SLANT MODEL SLIT LAMP with applanation tonometer—Black color. Two years old in perfect condition. Please contact R. D. Shapiro, M.D., 3893 E. Market St., Warren, Ohio 44484.

LOOKING for part-time service in anesthesiology in or near Columbus; have had 2 yrs approved residency training in anesthesiology, 1951-1953; since 1953 have been working on own general practice and anesthesiology. Reply: Box 651, c/o Ohio State Medical Journal.

WANTED: G.P. in Baltimore, Ohio (pop. 3000); ten miles from hospital; short driving distance to Columbus; Substantial financing available. Applicants should send their resumes to Kenneth E. Wooster, Mayor, Village of Baltimore, Ohio 43105.

RETIRING UROLOGIST has complete seven rooms of urological equipment and furniture for sale, excellent condition, consisting of two Young urological tables with G.E. head, resectiscopes, endoscopes and cystoscopes, etc. Dr. J. K. Nealon, 843 N. 21st Street, Newark, O. 43055; Phone (614) 366-1414.

NEW MEDICAL BLDG., 5 min. from downtown. WEST: 1959 Sullivant Ave., COLUMBUS, OHIO, 1400 Sq. Ft., full basement for storage. Just being completed; will partition to suit. Will sell or lease. Phone: (614) 878-2283, or 279-2349. Close to Mt. Carmel Hospital.

WANTED: LOCUM TENENS for busy general practice, major city Northeastern Ohio, for 2-3 months, starting late summer or as mutually agreeable. Keep all you make over expenses. Potential between $3,000 and $4,000 net per month. Stay on if you like it; take over practice in short time. Give all details in first letter. Write Box 652, c/o Ohio State Medical Journal.

FAMILY PRACTICE: Would you like to join my solo-practice (large city Northern Ohio), or share your practice with middle-aged G.P. to get out of the rat race, have longer vacations and more time for study? All replies strictly confidential. Write Box 653, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER has a favorable chance to settle in a community in N.W. Ohio. M.D. retired after 30 years in practice. Office and equipment available if desired. Modern hospital 8 miles away. Industry, recreation. Foreign graduate welcome. Write Box 644, c/o Ohio State Medical Journal.

AUCTION OF MEDICAL AND OFFICE EQUIPMENT — WEDNESDAY, JUNE 14, 1:30 p.m. Partial list includes: Bantom Bovie electrosurgical unit; Burdick ultrasonic unit with muscle stimulator; microscope; Medco-achilleometer; autoclave; scales; Tycos manometer cuffs; stethoscopes; examination and treatment tables; Stryker cast cutter; Cole X-Ray file; revolving stools; utility carts; surgical light; hemoglobinometers; Welch-Allyn desk sets with rechargeable handles, heads; hemostats; needle holders; forceps; speculums, etc. Also, desks; leather sidearm chairs; executive swivel chairs; G.E. portable intercom units; filing cabinets; Cincinnati time clock; Narce Post Rite Pegboard accounting system, with supplies. Sale being held at Junior Fair Building, Clinton Co. Fairgrounds, located on West Main Street, Wilmington, Ohio. Lunch served. Mrs. Frank G. Plymire, executrix, estate of Frank G. Plymire, M.D.

TWO OR THREE MEDICAL DOCTORS are needed in a growing residential community presently without any physicians. A nearly new building in pleasant surroundings with abundant parking area will be remodeled to satisfy the needs of those doctors coming here. The community is within 15 or 20 miles of Dayton, Kettering, Wilmington, and Middletown and within a 45 minute drive from Cincinnati. Contact: Thomas Cooper, The Friends Home, Inc., Waynesville, Ohio 45068.

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impotence

due to androgenic deficiency in the American male.

Android® 5

MUQETS
BUCCAL Tabs

Methyltestosterone N.F.-5 mg.

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Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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THE BROWN PHARMACEUTICAL CO., INC.
2500 West 6th Street, Los Angeles, California 90057

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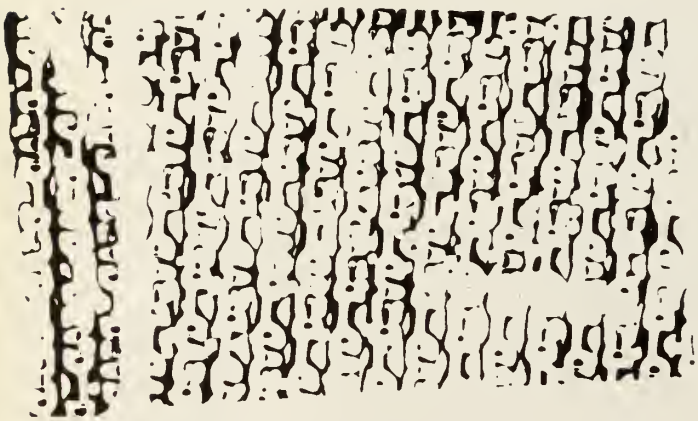
Librium (chlordiazepoxide HCl) and safety

Librium (chlordiazepoxide HCl), after more than a decade of wide clinical use, continues to reflect a wide margin of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

Antianxiety effectiveness: Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable, appropriate levels.

Effect on mental acuity: Usually minimal on proper maintenance dosage. (See Warnings in summary of prescribing information.)

Concomitant use: Is used as adjunctive antianxiety therapy concomitantly with cer tain specific medications of other classes of drugs, such as cardiac glycosides, antihyper tensive agents, diuretics and vasodilators.



in relief of clinically significant anxiety

Librium®

(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules
up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

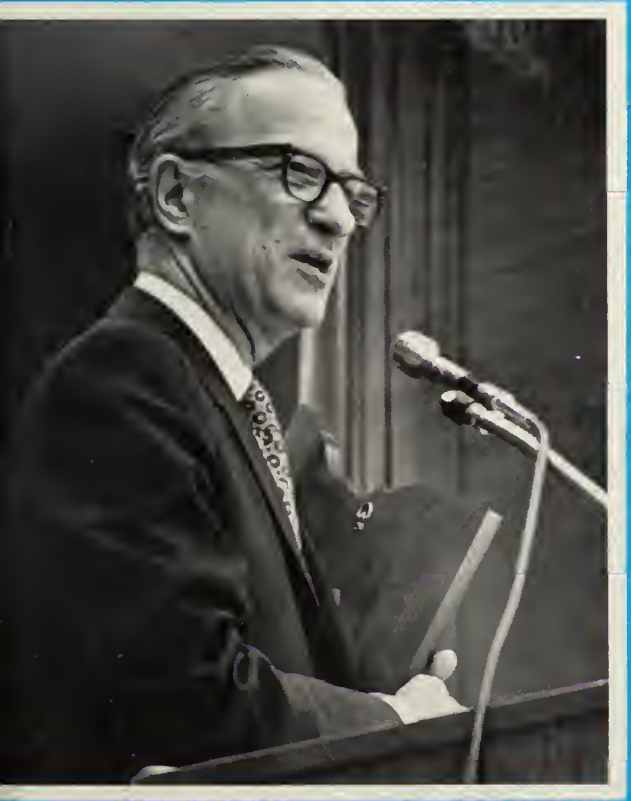
JULY • 1972
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FREDERICK T. MERCHANT, M. D.

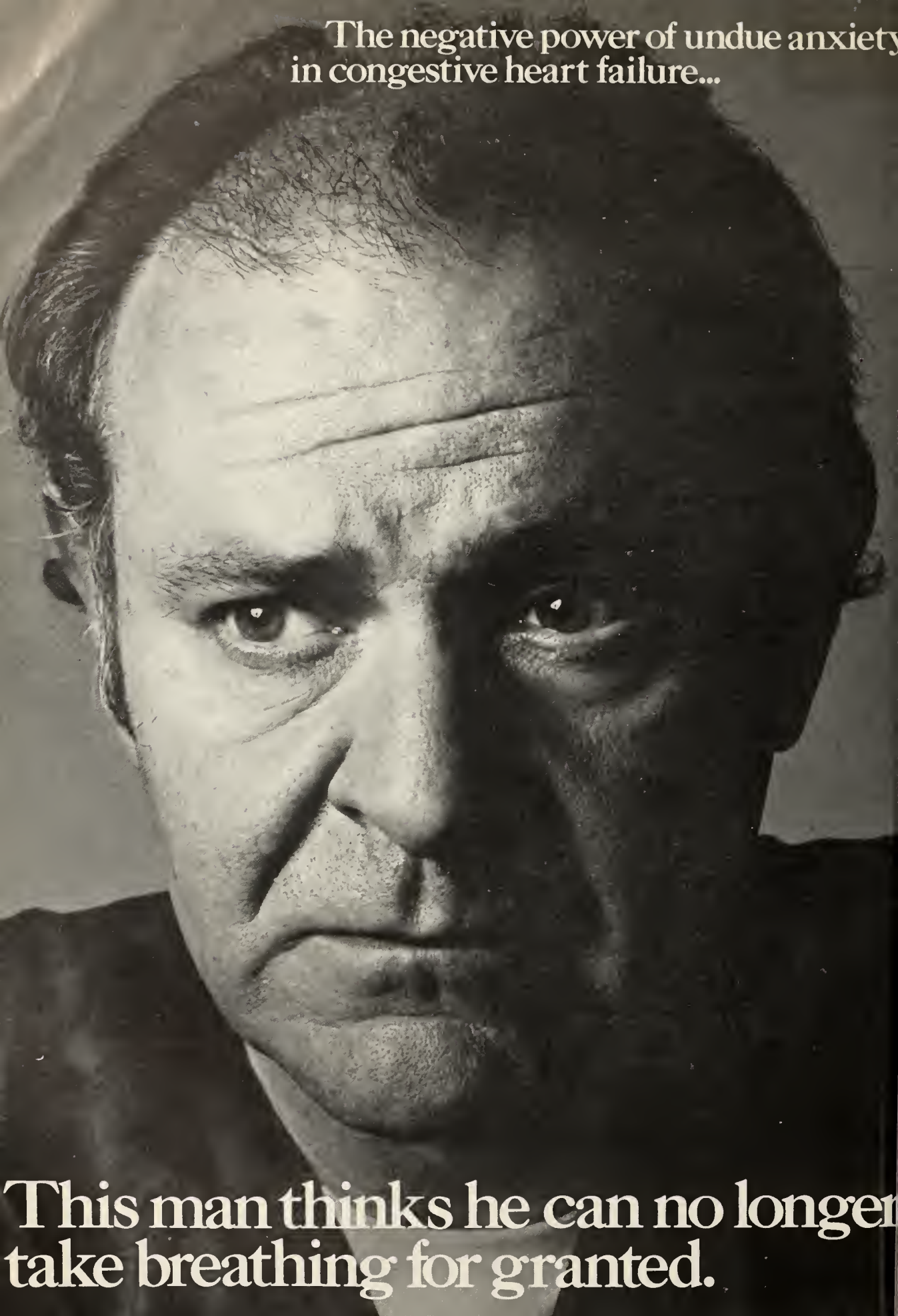


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EXCHANGE OFFICE
FRANCIS A. COUNTWAY
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BOSTON, MASS. 02115


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longer
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

JUL 1972

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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The Ohio State MEDICAL JOURNAL

VOL. 68 JULY, 1972 No. 7

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Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

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Precautions: Diagnostic and therapeutic measures necessa for optimal control with insulin are also necessary with Orinas The patient on Orinase must be fully instructed: about t nature of his disease; how to prevent and detect complication how to control his condition; not to neglect dietary restriction develop a careless attitude or disregard instructions relative body weight, exercise, personal hygiene, and avoidance of i fection; how to recognize and counteract impending hypogl cemia; how and when to test for glycosuria and ketonuria; h to use insulin; and to report to the physician immediately if h does not feel as well as usual.

Caution, very close observation, and careful adjustment dose are necessary when: insulin is withdrawn during the tri period in order to avoid ketosis, acidosis, and coma; thiazi diuretics are administered which may result in aggravation diabetic state and increased tolbutamide requirement, temp rary loss of control, or even secondary failure; treating patier with impaired hepatic and/or renal function and debilitated, m nourished, or semistarved patients in order to avoid severe hyp glycemia which may require corrective therapy over seve days; and treating patients with severe trauma, infection, or s gical procedures where temporary return to insulin or additi of insulin may be necessary. Response to tolbutamide is dim ished in patients receiving therapy with beta blocking agen

As some diabetics are not suitable candidates, it is essent that the physician familiarize himself with the indications, lim of application, and selection of patients for therapy.

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ian daily, and during the first month report at least once weekly or physical examination and definitive evaluation. After a month, xaminations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory owering or persistent elevation of blood sugar, or failure to btain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for naintaining standard diet regulation. Uncooperative patients hould be considered unsuitable for therapy. Prescriptions should e refilled only on specific instruction of physician. In treating nild asymptomatic diabetic patients with abnormal glucose olerance, glucose tolerance tests should be obtained at three- o six-month intervals. Orinase is not an oral insulin or a substiute for insulin and must not be used as sole therapy in juvenile liabetes or in diabetes complicated by acidosis or coma where nsulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, nay occur and may mimic acute neurologic disorders such as erebral thrombosis. Certain factors such as hepatic and renal lisease, malnutrition, advanced age, alcohol ingestion, and drenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and ncrease risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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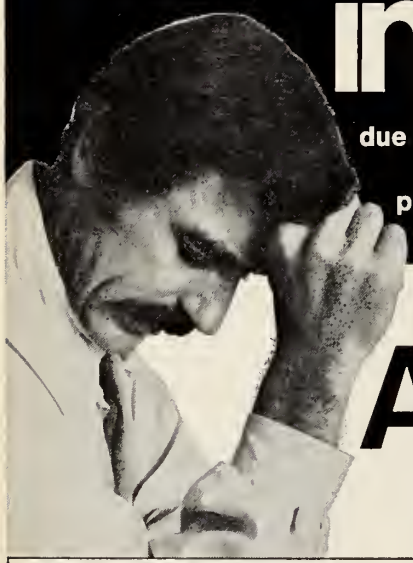
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Fertility and Sterility, January 1970
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardierenal disease and severe persistent hypercalcemia, ceronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canalieuli have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sotu impotence. Clin Med 12-69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestoteron thyroid compound. West Med 5-67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotenc Gen Prac 25-6, 1962. 4. **Hellman, L., Bradlew, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T.** Thyroid-androgen interrelations and the hypocholesteremic effect of andrsterone. J Clin Endocr 19-93 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesi J Urol 79-863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phil delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotenee in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Warren Osteopathic Physician Appointed to the State Medical Board

GOVERNOR JOHN J. GILLIGAN has appointed William Timmins Jr., D.O., a Warren osteopathic physician and surgeon, as the osteopathic member of the State Medical Board, for a four-year term. He succeeds James O. Watson, D.O., Columbus, long-standing osteopathic member of the Board.

Dr. Timmins received his D.O. degree from Kirksville College in 1941 and an additional degree from the Kansas City Physicians and Surgeons University in 1943. He received an M.A. degree in Political Science and Government from Catholic University in 1950.

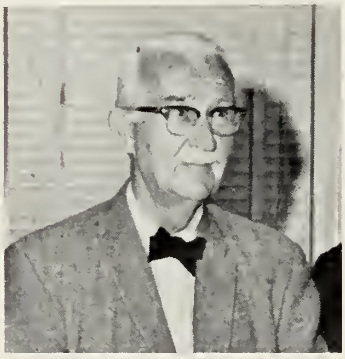


Wm. J. Timmins, D.O.

A former chief of staff of Warren General Hospital, he is a member of both the Ohio Osteopathic Association of Physicians and Surgeons and the American Osteopathic Association. He is also a life member of the American Committee for Maternal and Child Welfare and a member of the Trumbull County Mental Health and Retardation Board.

Dr. Timmins has been active in political affairs on the local, state, and national levels. He has served as chairman of the Trumbull County Board of Elections since 1962, as a member of the Democratic State Advisory Committee, as a delegate to the Democratic National Convention, and as a member of the Ohio Electoral College. Dr. Timmins is married and is the father of eight children.

The State Medical Board is the agency charged with the responsibility of licensing physicians and other practitioners of the healing arts and enforcing the law as it applies to the healing arts in Ohio. Under Ohio law, one member of the Board is an osteopathic physician and surgeon while the other seven are MDs.



James O. Watson, D.O.

Dr. Watson was first appointed to the State Medical Board in 1943 for a seven-year term and was subsequently appointed for three additional terms. He received his D.O. degree from Kirksville College in 1926 and holds honorary degrees from Kirksville and from the College of Osteopathic Medicine and Surgery, Des Moines.

He is a founder of Doctors Hospital, Columbus, and has served as a member of its Board of Trustees. He has also been associated with Dayton's Grandview Hospital and Delaware Osteopathic Hospital.

Dr. Watson has been active in both the Ohio Osteopathic Association of Physicians and Surgeons and the American Osteopathic Association, and received the AOA's Distinguished Service Certificate in 1955. He is a Fellow of the American College of Osteopathic Surgeons and served as its president for the 1962-1963 term. Dr. Watson is continuing his practice in Columbus and his activities in professional organizations.

Restrictions on Sale of Paregoric Noted

The following communication was released to *The Journal* by Frank E. Kunkel, executive director of the State Board of Pharmacy, State of Ohio.

Effective June 3, 1972 the sale of paregoric will be restricted to oral or written authorization by licensed prescribers.

The Food and Drug Administration order removing Paregoric from over-the-counter sale was issued upon request of the Bureau of Narcotics and Dangerous Drugs which supported the proposal as:

1. Providing better enforcement of the Controlled Substance Act of 1970 by eliminating problems encountered within states where Paregoric is not subject to prescription dispensing.

2. Eliminating problems experienced by practicing pharmacists because of differing policies toward Paregoric in adjacent states.

Pharmacists will be permitted to continue selling many paregoric-containing combination products because of their limited potential for abuse.

Essay on Schizophrenia

An award is being offered to the medical student, intern, or resident under 30 years of age who authors the best manuscript on "Schizophrenia." The essay can be devoted to any aspect of this illness. The winner also will receive a cash prize of $250 plus travel expenses to attend and to read the essay at the 5th Annual Taylor Manor Hospital Psychiatric Symposium in Ellicott City, Maryland, on April 7, 1973. Details may be obtained from Frank J. Ayd, Jr., M.D., Symposium Director, 912 West Lake Avenue, Baltimore, Maryland 21210.

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—George Sarton, from "The History of Medicine Versus the History of Art"

Would it be useful in clinical practice to have government predetermine drugs of choice?

Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

86.7%
No, it would not be useful.

Dialogue

Would it be useful in clinical practice to have government predetermine drugs of choice?

Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really b determined.

The Bureau of Drugs ha suggested the package in sert as a possible means communicating informatio on relative efficacy of drug to the physician. I find thi objectionable, since I d not believe the physicia should have to rely on thi source for final scientifi truth. There is also a prac tical objection: Since fe physicians actually dis pense drugs, they seldo see the package insert. I any event, I would mai tain that the physicia should know what drug h wants and why without d pending on the governmen or the manufacturer to te him.

Undoubtedly, physician are swamped by excessiv numbers of drugs in som therapeutic categories. An I am well aware that man drugs within such cate gories could be eliminate without any loss, or pe haps even some profit, t the practice of medicin But, in my opinion, neithe the FDA nor any othe single group has the expe tise and the wisdom nece sary to determine the or "drug of choice" in a areas of medical practice.

Maker of Medicine

neth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
li Lilly and Company



I my opinion, it is not unction of any governt or private regulatory cy to designate a "drug oice." This determinashould be made by the ician after he has re-d full information on properties of a drug, hen it will be based on xperience with this and his knowledge of ndividual patient who eking treatment.

I an evaluation of comtive efficacy were to be e, particularly by govnent, at the time a new is being approved for keting, it would be a t disservice to medi-and thus to the patient consumer. For exam-when a new therapeugent is introduced, on asis of limited knowlg, it may be considered e more potent, more ctive, or safer than ucts already on the ket. Conceivably, at time the new drug ul be labeled "the drug hoice." But as addiul clinical experience is mulated, new evidence a become available. ir, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audio-visual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B_{12} as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use – information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

Opinion & Dialogue

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CLARK
Richard L. Gilmor
Springfield

CUYAHOGA (Cleveland except as noted)
Rachel W. Abernathy
Munawar Ahmad
Thomas B. Bralliar
John J. Falko
Joseph Hauler
Alexander Jakubowycz
Alan Lubin
Chan J. Park
Mostafa Rezai
Painesville
Hermites M. Sanagustin
Gary Fred Stein
Martin B. Taliak

FRANKLIN (Columbus except as noted)
James M. Blackford
Stephen M. Cattaneo
W. David Dawdy
Westerville
Feliciano G. Dolor
Melinda C. Dolor
Martha E. Early
Pedrito A. Galupo
Edmond W. Gardner
Don E. Gebhart
Michael A. Hurwitz
Paul T. McGhee
Gail D. Miller
Worthington
Larry W. Shoemaker
Worthington
Richard H. Turner
Keith R. Woodroffe

HAMILTON
Edward F. Spievack
Cincinnati

LUCAS (Toledo)
Lachman Chablani
A. Willard Emch
Wassef E. Mikhail
Lala S. Mohan

MAHONING (Youngstown)
Carlos O. Cerrezuela
Daniel G. Corredor
Sadiq S. Husain

MONTGOMERY (Dayton except as noted)
John M. Duchak
Dewey O. Mays, Jr.
Thomas M. G. Rau
Patricia C. Simpson
Middletown
Santi Vibul

SENECA
Rosario D. Bello
Fostoria

SUMMIT (Akron except as noted)
Fred D. Barton
Daniel A. Bravo
John F. Clarke, Jr.
R. W. Malek
Barberton
Wayne A. Miller
Samuel T. S. Su
Cuyahoga Falls
Edward H. Thompson

TRUMBULL (Warren except as noted)
Eduardo T. Angnardo
Alfred R. Gorospe
Han Soo Shin
Pedro T. Yap
Newton Falls

WILLIAMS
Victor E. Badertscher
Bryan
Naranbhai L. Patel
West Unity

New Form Required for Schedule I and II Controlled Substances

The following communication was sent through medical organization channels by Alfred A. Russell, Chief, Registration & Audit Division, Bureau of Narcotics and Dangerous Drugs, with the request that it be made known to physicians.

I would like to request your assistance at this time in publicizing the fact that effective May 1, 1972, only Bureau of Narcotics and Dangerous Drugs Official Order Forms will be valid for transactions involving Schedule I and II controlled substances. Any practitioner may obtain the new forms by forwarding the old type IRS order form requisition (IRS Form 679) to the BNDD Registration Branch, P.O. Box 28083, Central Station, Washington, D.C. 20005.

The registrant's complete, nine-character BNDD registration number must be shown on the form in order that it may be processed. IRS Form 679 will not be honored as a valid requisition for official order forms after April 30, 1972. Therefore, this type requisition should be submitted as soon as possible. Any registrant who does not now have an IRS requisition, and who desires the new order forms, is required to complete form BND 222D and forward it to the Registration Branch. The BND 222D forms may be obtained from the Registration Branch or any BNDD Regional Office.

It would be a tremendous help to this Bureau's order form operation if the above information could be channeled to the various state and local Medical Society publications. . .

Ohio physicians who need BND 222D forms may write: Bureau of Narcotics and Dangerous Drugs, Room 357, Federal Building, Detroit, Mich. 48226.

The Commission on Cancer of the American College of Surgeons periodically surveys hospital cancer programs and grants approval to those which meet certain basic standards. The current list of 840 programs approved as of January 1, 1972 appeared in the April 1972 issue of the college's *Bulletin*. Copies are available from the college at 55 East Erie Street, Chicago, Illinois 60611.

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Clinical & Scientific Features



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Management of Severely Retarded Persons

A Discussion

LESLIE Y. CH'ENG, M.D.

IN THE PAST DECADE, the population of most state institutions for the mentally retarded has shown a significant change, with a marked increase in the percentage of severely and profoundly retarded persons. Formerly the population of a state institution for the mentally retarded might be grouped as one-third mildly retarded, one-third moderately retarded, and one-third severely and profoundly retarded. During the period of four years between January 1, 1967 and December 31, 1970, Broadview Center, with its 240 inpatient beds, has admitted 552 patients to its outpatient department and 535 patients to its inpatient department. In the inpatient department, the patient population is consistently divided into approximately 50 percent severely and profoundly retarded, 20 percent moderately retarded, and 30 percent mildly retarded. Around 15 percent of the inpatients are nonambulatory, "crib cases." This may not represent the picture in most or all state institutions for the mentally retarded in the nation but certainly indicates a trend towards a change in the population in such institutions and necessitates a re-evaluation of the treatment and care and the management of the severely and profoundly retarded persons.

Submitted October 28, 1971.

The Author

• Dr. Ch'eng, Brecksville, is Superintendent, Broadview Center for the Mentally Retarded.

Time for Re-evaluation

A survey of the public institutions for the treatment and training of mentally retarded persons in the 50 states of the nation shows that in 15 states the superintendents of all such institutions are physicians; in 18 states the superintendents are psychologists, educationists, social workers or other nonmedical professionals; and in 16 states they are physicians and nonmedical professionals mixed.[1] In one state the discipline of the superintendent is not specified. In the third category, there are more physicians than nonphysicians as superintendents in five states, more nonphysicians than physicians in six states,

and equal number of physicians and nonphysicians in the remaining five states. If the discipline of the superintendent reflects the general policy trend in the institution, one could probably infer that there is no uniformity in the purpose and goals of the state institutions in the different states. Physician superintendents most likely pattern the institutions after the medical model; psychologists, educationists, and social workers probably after the school or vocational shop model. This certainly calls for a closer look into the design and fate of state institutions for the mentally retarded in the future.

At a time when the Federal Government is considering establishment of special facilities for the research study, and treatment and care of persons with developmental disabilities, including mental retardation, cerebral palsy, and epilepsy, the medical profession should collectively and individually contribute to the planning with some bold innovation. Traditionally the severely and profoundly mentally retarded persons (the mental defectives) were placed in the state institutions ("state residential facilities") from infancy or early childhood. Even today it is not unusual to hear physicians, advising mothers with newborn infants suffering from Down's syndrome, say: "The baby is defective. Forget him now while it is still easy. Place him in a state institution where he will be under the constant care of experts." When a newborn infant suffers from severe cerebral palsy, the physician may say: "The baby has suffered severe brain damage. He will never walk or talk and may not live to adulthood. Place him in a state institution where he will get expert care and treatment." Such an infant is usually admitted to the medical and surgical unit of the institute and is raised often in a sterile atmosphere, both physically and emotionally. Annually 5 to 10 percent of such infants die from intercurrent infections or lack of "tender loving care." Those who survive become residents of the state institutions. They are not patients, but residents.

Changing Educational Goals and Practices in Public School Systems

During the past quarter of a century there has been a growing tendency to eliminate special schools for specific handicapped children and to give them special training in public schools. The state schools for the epileptics disappeared first and many of them were converted into state institutions for the mentally retarded. Some state schools for the blind are being closed and many special classes for blind children are being established in public schools. The deaf children are taught lipreading and not finger-sign language, so they can learn in special classes in public schools and are not required to be segregated in a special school where everybody, students, teachers, and other ancillary staff, communicate silently with their fingers. Many public schools, elementary, intermediate, and college, are building ramps and other structural modifications in the buildings to facilitate wheel-chair transportation by physically crippled students. Many elementary schools have special classes for crippled children. All public school systems have special classes for the educable mentally retarded and some also have special classes for the trainable mentally retarded. It is conceivable that in another one or two decades, all the trainable and educable mentally retarded children, with no special medical or psychological complications, will receive their education and training in the public schools. Only the severely and profoundly retarded, with severe medical complications, the moderately retarded with hyperactive, aggressive, and destructive behavior, and the mildly retarded with severe psychological complications, need to be admitted into state institutions, which should then be hospitals and not residential facilities.

Residential facility carries the connotation that the persons living in such an institution are "residents," that the institutions are their "homes," and that the superintendent of such an institution is nothing more than a hotel manager. Such arrangement may easily deteriorate into "human warehousing."

Management of Severely Retarded Persons—A Challenge

The crucial question now becomes how do we manage, care, and treat the severely and profoundly retarded with severe medical complications.[2,3] In order to offer realistic medical treatment for such severe complications, very few state institutions are properly and adequately equipped and staffed. They should be staffed with pediatricians and pediatric neurologists with ancillary paramedical staff and readily available consultation service from other medical specialties, such as orthopedics, physical medicine and rehabilitation, ophthalmology, otolaryngology, psychiatry, etc. To preserve an atmosphere of a hospital and not of a nursing home, only patients who require acute medical attention (diagnosis and treatment) may be admitted. A section of the hospital may be reserved for extended care and for the teaching and demonstration of nursing care to the operators of nursing homes. Otherwise the so-called hospital will be filled very

quickly with patients suffering from chronic, slowly deteriorating diseases and will not be able to attract qualified medical personnel–physicians, nurses, physical therapists, occupational therapists, etc. Many state institutions for the mentally retarded now operate their "medical and surgical unit" with a nurse and weekly or twice-a-week visits by a local practicing physician. This clearly indicates that many of the so-called medical and surgical or hospital units in state institutions for the mentally retarded are actually state-operated nursing homes.

Recognizing that the development of an infant and a young child depends immensely upon the continual loving care, support, guidance, and supervision of the mother; one could readily realize the importance of providing a positive mother-child, one-to-one adult-child, relation for the severely or profoundly mentally retarded child, if one expects the child to further develop what little intellectual endowment he possesses. Situations that would allow the development and continuous nurturing of this one-to-one adult-child relationship may be arranged in the following order of priorities: (a) maintenance of the child in his natural home; (b) placement in an adoptive home; (c) placement in foster home;[4,5] (d) placement in a small group home; and (e) lastly, placement in an institution where the children are "herded together" in a big ward of 40 or more children. This last instance is human warehousing and has no place in this affluent society in this modern age.

What Broadview Center Attempts to Do

Many of the patients admitted to the inpatient department at Broadview Center have no home to return to. Some homes may have a detrimental effect on the development of the child. Adoptive homes, even foster homes, are very difficult to find in a metropolitan area like Cleveland. It is, therefore, necessary to devise some intermediate procedure to meet the urgent need.

This led to the organization of a Family Care Unit at Broadview Center, which consists of a part-time physician, a full-time nurse with public health experience, and two social workers. Patients who have received maximum medical help in a hospital and require continual nursing care, such as those referred and transferred from the University hospitals or from our own hospital unit, are transferred to our family care unit if they can not be returned to their own homes. The two social workers either find or assist in developing foster homes and/or nursing homes and make the necessary arrangements for the placement of the patient. This includes, as a very important first step, the introduction of the nursing home operator to get acquainted with the patient and his or her responsible family members. The patient's parents are asked to visit the nursing home where their child will be placed. The Center supervises the medical treatment of the patients thus placed, mails to the nursing home the prescribed medication once every month, and receives reports from the nursing home operators as often as practical (monthly on all patients with convulsive disorder). The family care unit meets regularly once a week to discuss the progress and treatment program for the children placed in homes. The patient is brought back to the Center for his annual follow-up examination, which usually includes a physical examination, laboratory studies, tuberculin skin testing and necessary immunization, and whatever other examinations (psychological, educational, electroencephalography and x-ray studies) deemed necessary. This may be done in one or two days, during which time the patient will be considered a temporary inpatient. The nursing home operators are instructed to call our family care unit whenever a patient gets acutely ill or suffers an accidental injury. The family care nurse will contact a local physician to render the necessary emergency treatment and to assist us in deciding if the patient should be returned to the Center or be treated locally. The nurse and the social workers make regularly scheduled or unscheduled visits to these homes, confer with the operator and the nursing personnel regarding home care and treatment of the child. When the child reaches the level of maturation that he is ready to be enrolled in county classes for the trainable retarded, or ready for training in prevocational or sheltered workshop, the family care unit assists the home to enroll the child in a class or in a shop.

Nursing homes have been traditionally used by state mental hospitals as receiving homes for discharged patients with senile or arteriosclerotic dementia and for patients with chronic schizophrenia who have spent a major portion of their lives in state hospitals and have become "institutionalized." Therefore, operators and nursing personnel at these nursing homes are not looking for any improvement in the patients' general condition and behavior and are aiming to provide a pleasant and undemanding atmosphere for the elderly patient to enjoy as much as possible their remaining few years or months. They are not trained and oriented to stimulate patients for further development and improvement of their general adaptive behavior. More importantly,

they are neither accustomed nor prepared to receive children and youths.

The few homes that operate under the supervision of the Family and Children Services of the County Welfare Department have been offering good physical and nursing care of infants and young children, but they are not primarily designed to observe, stimulate, and train mentally retarded children in furthering their intellectual development and behavioral adaptation. Even such homes are too few in number. It is of utmost importance in the management of severely and profoundly retarded children, to develop many more small (five or six children) foster homes and nursing homes as satellites surrounding a small, active, treatment-oriented hospital unit in a central mental retardation institution.

Conclusions

1. The population in the State Institutions for the Mentally Retarded is rapidly changing with an increase in the number of severely and profoundly retarded with multiple medical complications and others with psychiatric or psychological problems.

2. There is a growing tendency for public school systems to provide educational opportunity to all children, including those with special handicaps.

3. Establishment of special facilities for the study and treatment of developmental disabilities should encourage all of us to re-evaluate what we have been doing and what we should plan to do with children with mental retardation, epilepsy, and cerebral palsy.

4. We suggest the consideration of creating a treatment oriented center for handicapped children, supported by a circle of small foster homes and/or nursing homes, to provide parent-surrogates for children who can not be returned to their natural homes and who need continual nursing care to further the development of endowed potentials.

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QUALITY OF MEDICAL CARE may be assessed on the basis of either the outcome of care or the process by which the care was given. To compare these two criteria, records and outcome were studied of patients with two common conditions, appendicitis and myocardial infarction. In three different hospitals the records of patients with the diagnosis of acute appendicitis had considerable disparity in the frequency of documentation of commonly sought symptoms or signs of this condition; yet at each hospital the disease was diagnosed with the same accuracy. Similarly, recorded data of patients with acute myocardial infarction showed no relation to various outcomes, including length of time lost from work, occurrences of angina, congestive heart failure, myocardial reinfarct and death. Thus, the orthodox method of audit for quality of medical care, based upon chart review of the recorded process of care, may be incomplete and misleading. — W. J. Fessel, M.B., and E. E. Van Brunt, M.D.. San Francisco: *The New England Journal of Medicine,* 286:134-138, Jan. 20, 1972.

Child Neglect and Abuse

A Study of Cases Evaluated at Columbus Children's Hospital in 1968-1969

Kenneth Zuckerman, Med. III; J. Philip Ambuel, M.D.; and Rosalyn Bandman, A.C.S.W.

IT WAS IN THE EARLY 1960's that the "battered child syndrome" was recognized as a unique disease entity. A symposium at the American Academy of Pediatrics meetings in 1961 and a study by Kempe reported in 1962 in the *Journal of the American Medical Association*[1] were the first steps in a program to alert physicians to this diagnosis. The increasing pediatric literature, along with laws requiring that suspected cases of abuse or neglect be reported to the authorities, has resulted in a greater awareness of the problem and a gradually increasing incidence of reported cases.

At Columbus Children's Hospital, all cases of suspected abuse are reported to the hospital social service department and to the law enforcement agency serving the area in which the child resides.

The records of the social service department revealed 20 reported cases in 1968 and 40 cases in 1969. The data for this study were derived from a review of these 60 cases.

Method

A review of all 60 hospital charts was done to determine the major physical and socioeconomic factors. Follow-up information was gained by reviewing the files of the local police department, the Children's Protective Agency, records of the social service department, and the child's hospital records.

Results

Twenty-five percent of the abused children evaluated at Columbus Children's Hospital in 1968 and 1969 were less than 1 year old, and 72 percent were under 5 years of age (Fig. 1).

More than half (54 percent) of these children had definite evidence, by history, physical examination, or x-ray studies of previously undiagnosed physical abuse. In another 21 percent of cases, previous abuse was suspected but could not be proven. There was no evidence of previous abuse in one fourth of the cases.

The most frequent physical findings are shown in Figure 2.

Several demographic characteristics of the families of the abused children were also studied. The annual family income was less than $5,000 in 72 percent of the families and from $5,000 to $10,000 in 15 percent. Income information from the remaining 13 percent of families was not available.

A study of family structure revealed that 45 percent of these children lived with both natural parents; 17 percent lived with one natural parent

Submitted October 5, 1971.

The Authors

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and one stepparent; 20 percent lived with their mother, who was divorced from their father; 15 percent lived with their mother who had never been married; and 3 percent lived with foster parents or guardians. In 40 percent of the cases there was no father or male guardian in the family.

Parental age varies widely with 20 percent of males and 15 percent of females over the age of 35 years.

In 21 percent of the families the father or male guardian was unemployed and in 19 percent of the homes there was a working mother. Seventy-one percent of the fathers or male guardians and 78 percent of the mothers or female guardians had not completed a high school education.

The person responsible for the abuse was father 25 percent, mother 25 percent, stepfather 12 percent, and mother's boyfriend 10 percent. In 23 percent of the cases, the abusing person was not identified.

Results from the analysis of our follow-up data revealed the following information about disposition and treatment:

	No. of Cases	%
1. Reported to appropriate police or sheriff's department	60	100.0
2. Referred to Franklin County Children's Services	28	47.0
3. Referred to children's services in other counties	2	3.0
4. Referred to Catholic Social Services	2	3.0
5. Had hearings in Juvenile or Domestic Relations Court	31	52.0
6. Referred to Criminal Court	22	37.0
Found guilty in Criminal Court	4	7.0
7. Referred for psychiatric treatment	10	17.0

In 20 cases, charges were brought but were then dropped because of lack of evidence.

Final outcome of these 60 cases can be summarized as follows:

	No.	%
1. Child abused by someone other than parent or guardian and placed back in his home.	10	17
2. Child abused by parent or guardian—released to home. (Of the 20 children released to home for this episode, four [or 7%] were removed from the home later because of a repeat incident).	20	33
3. Child abused by parent or guardian—held until the court hearing in custody of children's services, foster home, or with other relative—then released to home.	4	7
4. Child abused by parent or guardian—long-term placement by court in custody of Children's Services in Franklin County, foster home, or with other relative.	9	15
5. Child abused by parent or guardian—permanent placement with foster parent or other relative, or adopted.	11	18
6. Child abused by parent or guardian—child died.	2	3
7. Unknown—lost to follow-up.	4	7

During the process of gathering our follow-up data, certain deficiencies in record keeping and communication became evident. Of 54 cases referred to the Juvenile Division of the City Police Department, records were found on only 32 cases. In turn, the hospital social service department had no information of 12 cases who had been seen in the hospital and referred to the police. Of 28 cases referred to the Franklin County Children's Service, records were found on only 20 cases.

Discussion

The most striking observation made in this study is the inadequacy of our treatment and follow-up program. Of 22 cases referred for

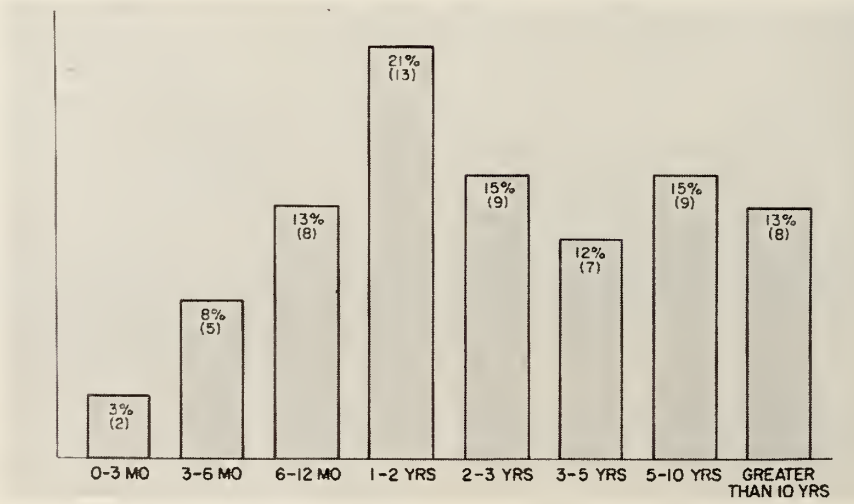


Fig. 1. Ages of abused children.

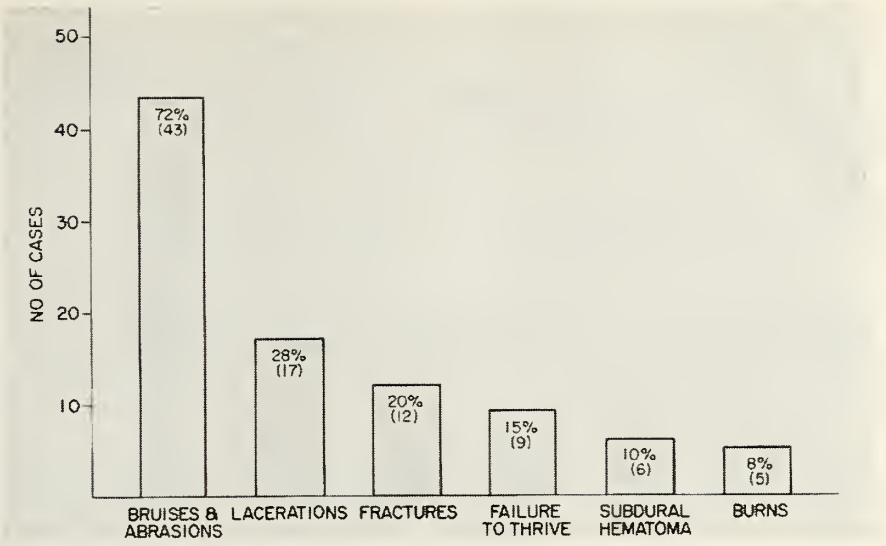


FIG. 2. Most frequent findings in abused children.

criminal prosecution, only four were convicted. In the convicted cases, the emphasis was on punishment of the adult rather than protection of the child.

In only 11 (18 percent) of the cases, was the child permanently removed from the home, and in only 20 (33 percent) of the cases, was ongoing guidance provided. In 38 (63 percent) of the cases, follow-up was left to the discretion of the parents.

The lack of coordination and poor communication among responsible agencies dealing with cases of child abuse and neglect is a contributing factor. A state-wide child abuse registry was established in Ohio as a result of the 1970 modifications of the State's child abuse laws. All suspected cases of child abuse are required by law to be registered. The county child welfare agency is responsible for reporting cases. On December 29, 1970, a report in *The Columbus Dispatch* (newspaper) indicated that 54 cases from Franklin County had been registered between January 1, 1970 and date of article. Approximately 50 cases had been reported from Children's Hospital alone, suggesting under-reporting from other agencies.

The rapid increase in the number of reported cases of child abuse should be noted. Prior to 1968, reports of suspected child abuse or neglect cases at Columbus Children's Hospital were quite rare. In 1968, there were 20 reported cases in the Columbus Children's Hospital and in 1969, there were twice as many. In 1970, the number of cases in the social service department records at Columbus Children's Hospital increased by nearly 50 percent over the number recorded in 1969. What is not known is whether this represents an increased incidence of child abuse or an increased incidence of cases being diagnosed and reported.

One major problem is the reluctance of physicians to report cases of suspected child abuse to the delegated authorities, which, by Ohio Law, are the local law enforcement agencies. There may be several explanations for this problem.

One possibility, of course, is lack of recognition of or failure of the physician to suspect child abuse in a case of trauma or failure to thrive.

Another possibility is that physicians simply do not wish to become involved with legal problems, which may require inordinate amounts of the physician's time and effort. Also, the physician may not wish to subject himself to possible harassment or adverse publicity, both of which may result from legal entanglements.

A closely associated problem is the physician's reluctance to involve his private patients or even complete strangers in the expense and embarrassment of legal actions, particularly in cases in which he can only strongly suspect child abuse or neglect of the child.

If the case eventually reaches criminal court, as occurred in 37 percent of the cases included in this study, the probability of conviction is very small, as evidenced by the total of four criminal convictions in the 60 cases of child abuse that were studied. This study revealed two probable reasons for these findings: (1) In many cases an angry parent pressed charges against the one who abused the child, and later dropped the charges or refused to testify. (2) Conviction was usually impossible because of lack of witnesses to the abuse or any more than circumstantial evidence. The penalties for those people convicted of child

abuse were lenient. The following are the results of the four convictions noted in the present study:

1. Stepfather— 50 days in jail (suspended sentence), $50 fine, one year probation.
2. Boyfriend of mother—Short term in workhouse (exact time unknown).
3. Mother—Six months probation.
4. Stepfather—Pleaded guilty and paid court costs.

Criminal prosecution, whether successful or not, probably does nothing to prevent recurrence unless the child is permanently removed from the home. Recurrence rates are high unless the involved parent is provided with an active treatment program.

Thus, it is almost certain to be most frustrating and unrewarding for the physician to report the cases to the local law enforcement. For this reason, the physician may tend to ignore the problem for the sake of saving the family and himself a great deal of trouble and for the sake of maintaining his rapport with the patient's family; or he may attempt to deal with this difficult problem himself, although he may be untrained and unprepared to cope with it.

It should be mentioned that the population from which this study group has been taken is not necessarily representative of the general population. The overwhelming majority of the patients seen in the Columbus Children's Hospital emergency room and outpatient clinics are from the lower socioeconomic groups. Thus, the finding that more than 75 percent of the children in this study were from families with yearly income of less than $5,000 was, in all likelihood, more a reflection of the population served by Columbus Children's Hospital than of the types of family in which we are most likely to observe the occurrence of child abuse and neglect. We can make no certain statements about the incidence or type of child abuse that might be seen in families from the middle and upper socioeconomic classes, because our study population included very few middle-class and no upper-class children.

Another important group of abused children, who are not included per se in this study, are those who are psychologically abused. This is certainly a far larger group than the physically abused children; however, this is a far less frequently recognized problem. There were no such reports filed by physicians at Columbus Children's Hospital, or by anyone else in the Columbus area, to the local law enforcement authorities. This type of child abuse is far less apparent to professional observers than is physical abuse; but it is more insidious in its onset and is quite often more damaging to the child as the abuse progresses in intensity over the course of several years. Psychological abuse is almost impossible for a physician to recognize when he has seen the patient and possibly his family only once or a few times. This is one area of abuse in which professionals who have more frequent contact with the children than do physicians should be more attuned to the problem. Teachers, social workers, and recreational supervisors must be trained to recognize children and families in which psychological abuse is occurring which is obstructing the normal personality development of the child.

Possible improvement in the management of this difficult problem could be achieved if the following suggestions would be implemented:

1. Prosecution, except in the most extreme cases, should be carried out under a Child Neglect Law which emphasizes protection rather than a Child Abuse Law which emphasizes criminal prosecution and punishment. The children in these families should be maintained under court-ordered protective custody until there is reasonable evidence that changes have occurred, and that the child will not again be in danger of abuse. Evidence from many studies has shown that parents need help. During the protective custody the family should be under observation so that treatment can be provided.

2. One agency should provide the follow-up and treatment services. In some cases this would be the county children's services but in many cases it might be more effective if the county agency contracted with a private agency for the service.

3. All agencies should upgrade their record systems and constant efforts need to be made to maintain communication. Ohio law now requires a central registry but ways must be found for disseminating information from that registry to those caring for children.

4. Physicians, nurses, teachers, and others must be made more aware of this problem and be more willing to intervene when the problem is noted.

Summary

A review of the outcome in 60 cases of child abuse is reported. In the 50 cases in which parent or guardian was thought to be responsible, final outcome revealed that: two died, four were lost to follow-up, nine were provided long-term placement outside the home, 11 were permanently removed from the home, and 24 were returned home, four of whom were later removed because of a second incident. Of 22 cases referred to Criminal Court, in four, the offenders were found guilty. In 20 cases, some ongoing guidance was provided.

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Bronchial Brushing
A Community Hospital Procedure

Dan E. Meininger, M.D.; James W. Funkhouser, M.D.; and Mohammed Yunus, M.D.

BRONCHIAL BRUSHING with TV fluoroscopy has been an accepted diagnostic procedure for indeterminate pulmonary lesions since the description by Hattori in 1964.[1] Several other series have appeared in literature,[2-4] but these articles have not emphasized the relative facility and ease with which this procedure can be done in radiology departments already doing arteriography and other special procedures. Prior to 1969, undiagnosed pulmonary lesions at Miami Valley Hospital were studied by sputum cytology; by bronchoscopy with biopsy; were surgically resected; or more recently, were needle biopsied. Each procedure had limitations either in extent of visualization (bronchoscopy) or in relative hazard to the patient (surgery and needle biopsy). Bronchial brushing is not affected by the above limitations since virtually any part of the lung can be brushed. Patient discomfort and risk are minimal.

The Author

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Indications

We now recommend that bronchial brushing be done after three negative sputum examinations for cytology and bacteriologic pathogens. Many patients with peripheral lesions do not produce sputum. In these, bronchial brushing should be done as the initial study following radiography and possibly planography. The lesion must be large enough to be localized by fluoroscopy. The largest group of patients with indication for brushing is comprised of those suspected of bronchogenic carcinoma, who are not surgical candidates and who need a diagnosis prior to institution of radiation therapy or chemotherapy. Accurate cytologic diagnosis is essential, and an experienced cytology laboratory with a cytopathologist should be available. The only contraindications are blood coagulation defect and history of sensitivity to local anesthetic agents.

Submitted August 6, 1971.

Technique

The procedure involves the selective placement of a catheter and brush into a pulmonary lesion. A prior bronchogram is helpful in this placement, but it is not a necessity. We have adopted the transcricothyroid membrane approach for bronchial brushing for the following reasons:

1. The required catheter is short and is easily manipulated.
2. Transcricoid anesthesia is excellent with small amounts of anesthetic agent.
3. Patient discomfort during and after procedure is minimal.[5,6]

Materials needed are:

1. 2% lidocaine, 10-cc syringe, 23-gauge and

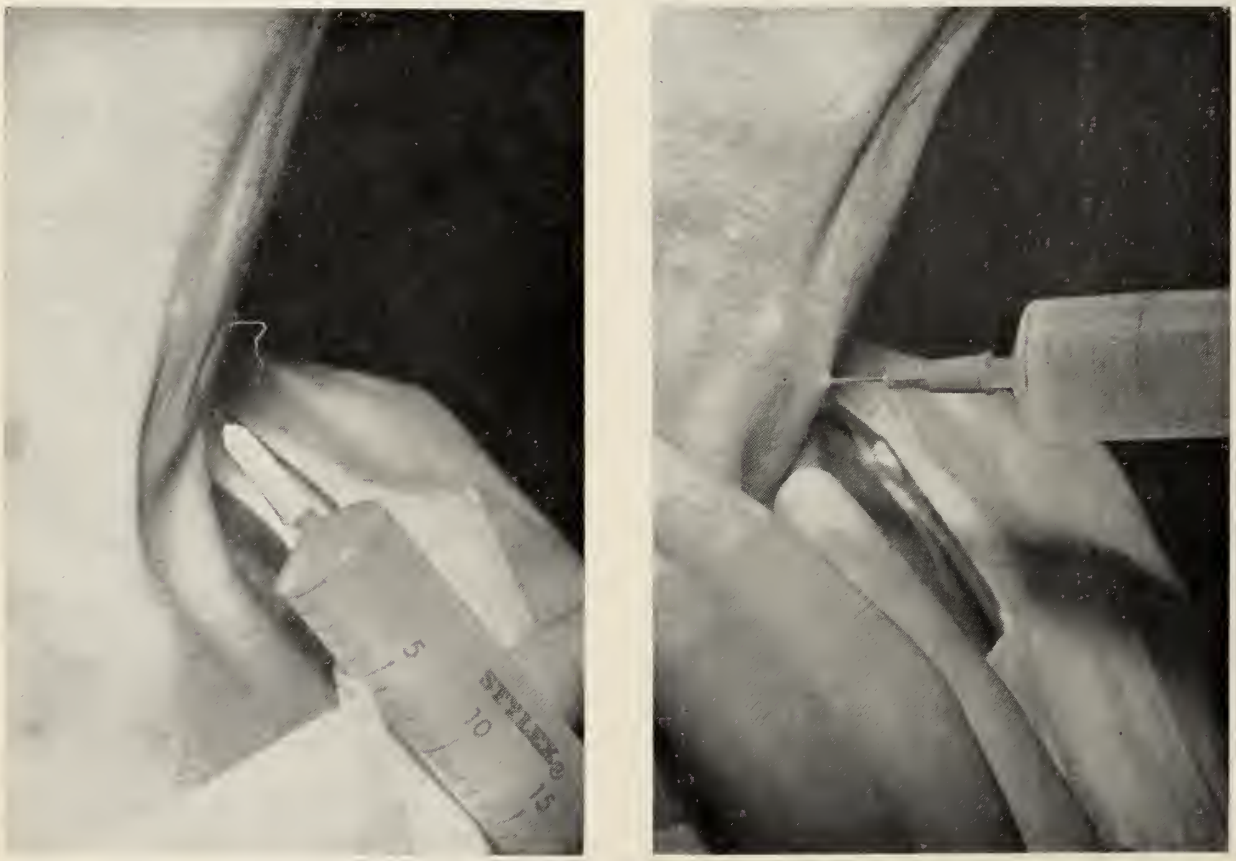
21-gauge needles
2. 15 T Thin wall percutaneous needle*
3. TSF 52-80 safety spring guide*
4. Thinwall polyethylene catheter (red) Fr. 7.1*
5. Bronchial brushes (nylon) 1.72-mm diameter. 36″ extension†

Premedication is 60 mg codeine, 0.4 mg atropine intramuscularly. 30 minutes prior to the procedure Oral intake should be withheld for eight hours prior to study. The patient is seated on the footboard of an upright fluoroscopic table and is prepared for surgery, draped, and fitted with a disposable face mask. A midline skin wheal is raised with local anesthetic over the cricothyroid membrane. The cricothyroid membrane is punctured with a 21-gauge needle and the patient is instructed to expire. Two to four cc of local anesthetic is injected rapidly into the trachea and the needle is withdrawn while the patient coughs (Fig. 1). This step is repeated with two more cc of lidocaine. The patient is then placed supine on the table with the head extended. A small midline transverse skin puncture is made with a size 11 blade before insertion of the arteriographic needle. The larynx is held firmly with the left hand while a puncture of the cricothyroid membrane is made with the needle. The tip of the needle is directed caudad about 15° and is replaced by first the guide and then the catheter. A preshaped polyethylene catheter is placed in the main bronchus on the side of interest and another two cc of local anesthetic is injected. Fluoroscopic placement of the catheter can then be done using a television system (preferable) or mirror view image intensification. Three catheter bends are needed depending upon the pulmonary segment involved:

1. A "J" shape for upper lobes
2. A 90° angle for lingula, middle lobe, and superior segments
3. A 30° angle for basal segments

Lesser degrees of curve can be obtained during the procedure by temporarily reinserting the rigid end of the guide in order to obtain placement in the desired segment or subsegment. Several special types of brushes and biopsy forceps

*Available from Cook, Inc., Bloomington, Indiana
†Available from Mill-Rose Company, Mentor, Ohio



Figs. 1. Patient is sitting on fluoroscopic table footboard. Technique of transcricothyroid membrane (left — skin, and right — tracheal) anesthesia shown.



FIG. 2. Anteroposterior film of chest showing right apical lesion.



FIG. 3. Anteroposterior 70-mm spot film of right apical lesion, guidewire, and catheter in position.

have been designed in order to extend the usefulness of bronchial brushing.[7-9] These devices have value in the lesion near the periphery of the lung and particularly in the extra-bronchial metastatic mass. The polyethylene (Fr. 7.1) catheter which we have employed nearly reaches the pleural surface of the lung. Approaching or entering a suspect lesion has almost always been possible with the selection of curves described above. Specialized curves can be formed even during the brushing procedure by inserting the polyethylene catheter and curved guide into hot water. We attempt to enter or penetrate all suspect nodules, masses, and infiltrations with the catheter and brush. It is important to obtain anteroposterior and lateral spot films to confirm radiographic placements (Figs. 2 and 3). Occasionally these films will reveal that the lesion was missed at fluoroscopy.

A brush is then inserted into the catheter and vigorous brushing of the lesion or the involved bronchus is done with a minimum of three to four separate brushes (Fig. 4). Aspiration of the catheter is done before removal and rinsing of the catheter is done after removal in order to obtain more material for study. Brushes and specimens are sent for cytologic studies and are cultured for routine organisms, acid-fast, and fungus. A Band-Aid® is placed over the puncture site, and the patient is instructed to hold a finger over the area when coughing for the subsequent 24 hours. Post-brush specimens are important and must be obtained by the nursing staff. Results are shown in Table 1.

TABLE 1. Results of Bronchial Brushing with TV Fluoroscopy

Cytologic Diagnosis in 65 Consecutive Patients	
Positive for cancer	36
Negative for cancer	29
Clinical and Tissue Diagnosis in 55 Patients	
Cancer (all types)	43
No cancer (inflammatory and miscellaneous)	22
Clinical Accuracy in Cancer Diagnosis	
True positive and negative	85%
False positive and negative	15%

The statistics are not reported for accuracy in inflammatory lesions though the correct bacteriologic diagnosis has been made frequently in those cytologically negative. Seven patients had a false negative diagnosis. Incorrect brush localization and poor patient selection accounted for these errors. With regard to patient selection, we no longer brush patients presenting with only nodal metastasis or superior vena caval syndrome



Fig. 4. Patient is supine; polyethylene catheter placement shown.

where a peripheral lesion can not be clearly identified on the radiographs.

In this series, 12 cases failed to produce a cytologic diagnosis; however, if post-brushing sputums are included, this figure is reduced by half, thus increasing the overall accuracy. Repeat brushing will increase accuracy if there is some question as to proper brush placement. From a cytologic standpoint, repeat brushing may cause false interpretation due to severe cell atypia from regenerating epithelium. This situation has been observed in two of our cases.

Complications

Potential complications include anesthetic reaction, hemorrhage, pneumothorax, and neck emphysema. One patient in our series had hemorrhage of about 60 cc and also developed an unexplained pneumothorax on the opposite side from the brushing. His recovery was uneventful. There were no other complications.

Conclusion

1. Bronchial brushing can be done in most radiology departments with readily available equipment.

2. Results are highly accurate especially in primary pulmonary carcinoma.

3. The patient discomfort and complication rate are almost negligible.

4. Diagnosis is established promptly thus freeing needed hospital beds.

5. Patients are frequently spared a diagnostic thoracotomy or needle biopsy.

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Cor Pulmonale

A Retrospective Study of 100 Patients

Mansur Zarraby, M.D., and Adil Ghafour, M.D.

CHRONIC RESPIRATORY DISEASES, particularly chronic bronchitis and pulmonary emphysema, are becoming increasingly more frequent problems for the physician. Responsible for this trend appear to be the growing longevity of the population and the continued exposure to respiratory irritants, including heavy cigarette smoking.

The term "cor pulmonale" is frequently misused and misunderstood. It comes from the Latin words *cor,* meaning heart, and *pulmo,* meaning lung. In a strict sense, cor pulmonale refers to hypertrophy or failure of the right ventricle, resulting from a primary lung disease. After much debate about the term cor pulmonale, a committee of the World Health Organization decided in 1963 to define this disease as right ventricular hypertrophy resulting from any type of abnormality of the respiratory structure or function.[1]

We studied 100 patients with this diagnosis from the standpoint of etiology, clinical features, laboratory findings, ie, electrocardiograms (ECG's) and pulmonary function tests, and mortality rate. The purpose of this paper is to report our findings.

Selection of Patients

Included in our study were the last 100 patients admitted to the Veterans Administration Hospital, Dayton, Ohio, who had the final diagnosis of cor pulmonale established. All of them had primary lung disease with evidence of right-sided heart failure or ECG findings of right ventricular hypertrophy or pattern suggesting cor pulmonale, ie, P-pulmonale, QRS with low voltage, S_1, S_2, S_3 pattern and clockwise rotation. Their records were reviewed and analyzed for a history of chronic bronchitis and pulmonary emphysema, according to the classification and definition of the American Thoracic Society;[2] clinical and physical evidence, such as dyspnea on exertion and right-sided heart failure; ECG findings of cor pulmonale; pulmonary function tests; arterial blood gas studies; and autopsy findings in 26 cases.

Submitted August 12, 1971.

The Authors

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- Dr. Ghafour, Dayton, is Director, Cardiopulmonary Laboratory, Veterans Administration Center.

Results

All 100 patients were male, with an average age of 57.8 years. Fifteen of them were within the range of 35 to 45 years, 55 between 45 and 65, and 30 between 55 and 80 years of age.

Underlying Heart Disease. One patient had hypertensive cardiovascular disease; arteriosclerotic heart disease was suspected in five. Only one of these had atrial fibrillation, however, his autopsy findings revealed no evidence of significant coronary atherosclerosis.

Duration of Lung Disease. Eighty patients had provided accurate information regarding the

duration of their pulmonary disease, which varied from 3 to 30 years.

Etiology. Ninety-six patients had a history of cigarette smoking; 86 had chronic bronchitis; there were 85 with pulmonary emphysema; 60 had repeated pneumonia; 14 had bronchial asthma; and 14 had tuberculosis; and silicosis was present in four patients (Fig. 1). A few patients gave no contributory history.

Clinical Symptoms and Signs. As shown in Figures 2 and 3, nearly all patients had a chronic cough and 90 had dyspnea on exertion. Orthopnea was present in 68 patients, and 39 patients complained of paroxysmal nocturnal dyspnea. Clubbing of the fingers was noted in 30 patients, obstructive pulmonary emphysema in 82, hepatomegaly in 44, cyanosis in 42, pitting edema in 41,

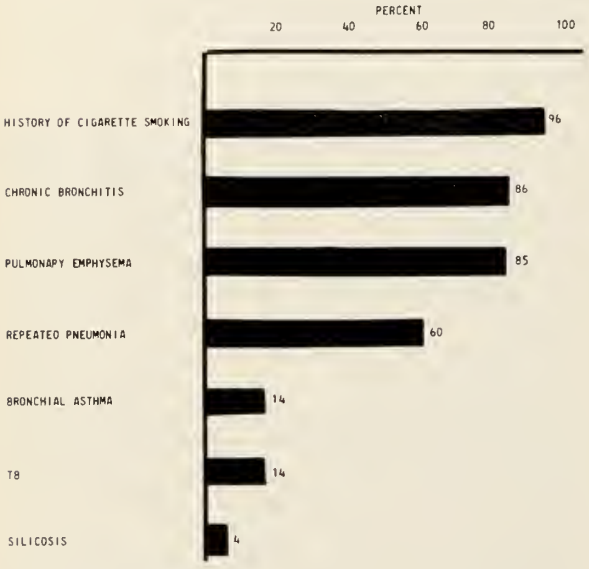


Fig. 1. Clinical etiology.

and polycythemia in 10 (hematocrit reading higher than 55 percent, hemoglobin more than 17 gm per 100 ml).

Electrocardiographic Pattern. The ECG's of 83 patients showed evidence of right atrial overload and 28 of right ventricular hypertrophy. The ECG patterns were highly suggestive of myocardial infarction in 18 patients, five of whom were in the area of the inferior wall, the rest in the anteroseptal wall. Autopsy did not confirm this diagnosis. Left ventricular hypertrophy was present in one patient, whose ECG had resembled an infarct pattern.

Sinus rhythm was found in 91 patients, of whom 83 had sinus tachycardia. Right bundle branch block was noted in 37 patients; clockwise rotation in 87; right axis deviation in 47; tran-

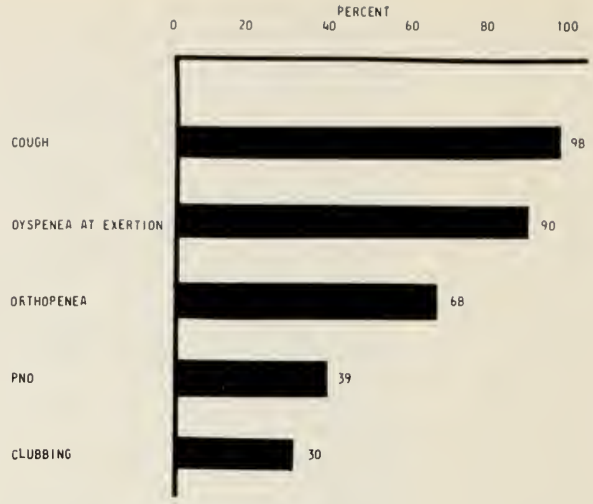


Fig. 2. Predominant symptoms.

sitory premature ventricular contractions, originating from the right or left ventricle, in 27. Only four patients had atrial fibrillation, two of these with an infarct pattern (Figs. 4 and 5) and one had atrial flutter.

Arterial Blood Gas Study and Pulmonary Function. Arterial blood gas studies of 45 patients showed severe respiratory acidosis in 30, milder cases in 15. Interestingly enough, in 23 of the 41 patients who died, the studies disclosed mild or severe respiratory acidosis. Pulmonary function tests were given to 37 of these patients and revealed obstructive lung disease in 28, a combination of obstructive and restrictive lung disease in seven. Two had restrictive patterns only.

Roentgenographic Findings. The hearts of ten patients were enlarged according to radio-

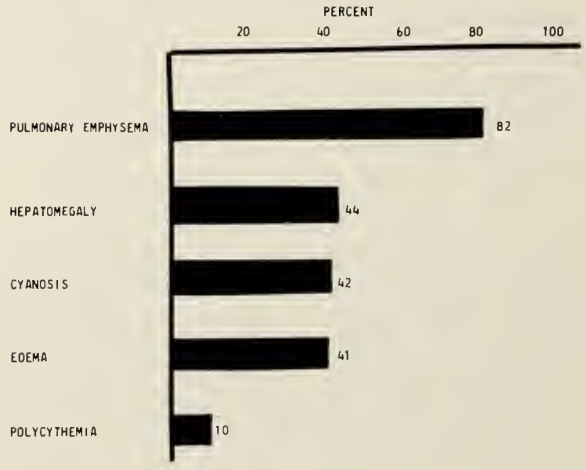


Fig. 3. Predominant signs.

logic criteria. A great number showed evidence of bullae and changes clearly emphysematous or suggestive of emphysema.

Tracheostomy. Tracheostomy for management of respiratory failure was performed on 20 patients.

Capacity to Work. None of the patients in our series was able to work during the five years before death because of shortness of breath or other symptoms.

Pathologic Findings. Autopsies performed on 27 patients showed normal coronary arteries. Of these 27 patients, 16 had right ventricular hypertrophy (thickness greater than 0.6 cm); the rest had evidence of right ventricular dilatation.

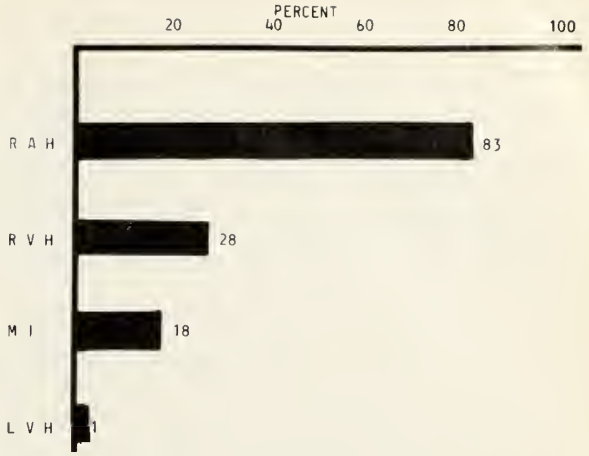


FIG. 4. Strain patterns found in ECG.

Discussion

Our study of patients with cor pulmonale shows a high incidence of smoking (96 percent). Occupational diseases were not so prevalent, only four patients having a history of silicosis. Fourteen patients had tuberculosis. One of the striking features in the clinical symptomatology was the presence of chronic cough in 98 patients. Many also had orthopnea and paroxysmal nocturnal dyspnea. Polycythemia was evident in ten patients.

In interpreting the ECG's of patients with emphysema, several points must be considered. First, emphysema alone may produce alterations in the ECG.[3] Thus, the criteria for the diagnosis of right ventricular hypertrophy must be separated from those of emphysema per se. Second, since emphysema alters the ECG, it tends to obscure the ECG manifestation of right ventricular hypertrophy.[3] Third, the ECG may appear to be perfectly normal even in the presence of significant cor pulmonale. Lastly, emphysema and cor pulmonale may alter the ECG, to such an extent that grossly erroneous interpretations occur, as reported by Phillips and Burch,[4] and this was apparent in 18 of our cases. Their ECG's were interpreted as having an infarct pattern, of which 13 suggested anteroseptal infarction, the rest inferior wall myocardial infarction. Autopsy of 5 of these 18 patients showed no evidence of any significant coronary artery disease.

In right ventricular hypertrophy (cor pulmonale) of pulmonary emphysema, two basic causative factors are at work. One — by far the more important — is a pressure load, the other a volume load.[5] However, it is not infrequent that autopsy reveals a right ventricle which seems to have reflected primarily a volume load, namely, with hypertrophy of the crista supraventricularis.[6] Actually, it will be clear that the ECG manifestation of right ventricular abnormality (hypertrophy of the free wall or of crista supraventricularis) depends somewhat upon the underlying etiology and the associated diseases (eg, atrial septal defect, pulmonary stenosis, cor pulmonale). In this study, only 28 patients were seen with the classical pattern of right ventricular hypertrophy and an R/S ratio in the right precordial leads greater than unity and with a predominant R wave pattern. Electrocardiographic findings of right ventricular hypertrophy in 27 patients were confirmed at autopsy in 16 cases. In general, the effects of emphysema on the ECG appear to be due to two factors: a change in the anatomic position of the heart, and the interposition of a hyperinflated lung.[7] These may cause a positional rotation of the main QRS vector in the horizontal plane and contribute to a shift of the transition zone to the left and a marked clockwise rotation.[8] This was true for 87 of our cases. We also found a very low incidence (4 percent) of arrhythmias, such as atrial fibrillation. Interestingly enough,

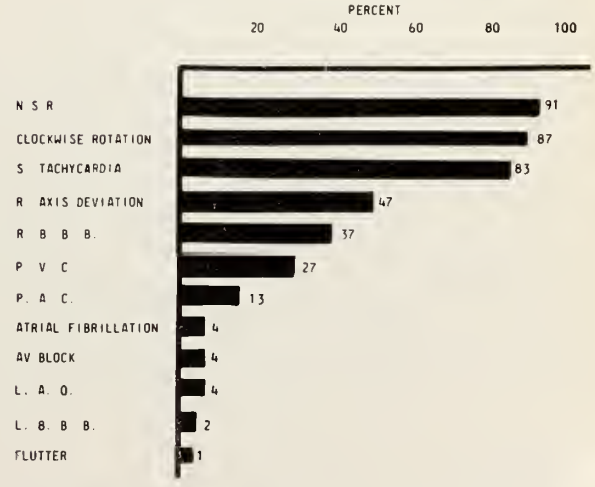


FIG. 5. Rhythm and conduction found in ECG.

in two of these the ECG was interpreted as indicative of myocardial infarction.

The majority of the patients with premature ventricular contractions were taking digitalis. Sinus rhythm was most frequently encountered. We found an increased incidence of mortality rate in patients with mild to severe respiratory acidosis, which agreed with previous reports that repeated congestive heart failure or respiratory acidosis result in a higher mortality rate.[9,10]

Pulmonary function tests in 37 patients showed a combination of obstructive and restrictive lung disease. The presence of emphysema may make the radiologic detection of cardiac abnormality very difficult because the heart is pulled downward by the diaphragm, and the chest volume is increased. Furthermore, the anterior location of the right ventricle prevents an accurate estimation of the heart size and the erect posteroanterior view is not well suited for the detection of abnormalities in this chamber. Only ten of our patients had cardiomegaly by roentgenogram, but we observed emphysematous changes, such as low diaphragm, increased perihilar and decreased pulmonary vascular markings in the majority of the cases. Tracheostomy for the management of respiratory failure was the procedure of choice in this group. Even so, more than 50 percent were unable to work because of their increasing shortness of breath.

Summary

The medical histories and principal clinical and laboratory findings of 100 cases of cor pulmonale are analyzed: The majority of the patients were cigarette smokers. Orthopnea and paroxysmal nocturnal dyspnea were frequent; atrial fibrillation and flutter were only rare occurrences in this population. The relative value of ECG in determining the magnitude of right atrial and right ventricular hypertrophy was discussed as well as the possibility of erroneous diagnosis of myocardial infarction, especially in the area of the anteroseptal wall. Of interest was the high mortality rate in patients with repeated heart failure and respiratory acidosis.

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CHIROPRACTIC SERVICES. — The unprecedented demand for medical services in the United States, coupled with the increasing involvement of governmental agencies in paying for them, has led politicians and others to press for the inclusion of chiropractic services as an alternate method for providing health care in programs sponsored by the federal government. There is reason to believe that the public, the politicians, and the physicians are in large measure ignorant of or indifferent to the fundamental problems involved in such a proposal. A review of existing information relative to the theory, scope, and quality of chiropractic practice and the education of chiropractors leads to the conclusion that the use of chiropractic in health-care programs is not in the public interest. — H. Thomas Ballantine, Jr., M.D., Boston: *The New England Journal of Medicine,* 286:237-242, Feb. 3, 1972.

Bell's Palsy—Current Trends in Therapy

Edward L. Hendershot, M.D.

A PATIENT with a sudden facial paralysis is one with deep psychological trauma. He usually sees his doctor immediately and is relieved that he has not suffered a stroke. He is then left with the unsettling news that "90 percent of these cases clear up." The patient becomes quite anxious if he does not recover promptly, and his anxiety is well-founded. The sad fact is that if discrimination is used, only about 55 percent of patients recover completely. Weak function and synkinesis or "associated movements" do not constitute satisfactory recovery. Enough cases have been gathered and studied to arrive at some definite conclusions about Bell's palsy. In Matthews series of 145 patients,[1] results were graded as follows: (a) complete recovery; (b) incomplete grade 1 — incomplete recovery with no disability; (c) incomplete grade 2—incomplete recovery with slight disability; and (d) grade 3—poor result. He was able to relate the degree of recovery to the time of first movement (Table 1).* It is obvious from this series that Bell's palsy deserves much better diagnostic evaluation and more intensive therapy than is commonly given.

Table 1. Degree of Recovery

Movement Observed	Complete Recovery	Grade 1	Grade 2	Grade 3	Total
4 weeks	74	6	18	4	102
4 to 8 weeks	0	1	10	7	18
8 to 12 weeks	0	0	4	7	11
12 or more weeks	0	0	1	13	14
Total	74	7	33	31	145

*From Matthews[1]

Anatomy and Pathology

The facial nerve is unique, in that no other nerve spends so much of its time coursing through bone. It enters the temporal bone through the internal auditory canal and immediately courses anteriorly and superiorly, to become the geniculate ganglion, where the greater superficial petrosal nerve arises. This nerve is responsible for lacrimation. It then curves posteriorly, enters the middle ear, and travels just beneath the horizontal semicircular canal. Just posterior to the level of the posterior portion of the ear canal, it again bends and courses inferiorly, giving off the nerve to the stapedius muscle and the chorda tympani nerve, which supplies the taste sensation to the anterior two-thirds of the tongue. It exits the temporal bone at the stylomastoid foramen.

The accepted theory of the production of Bell's palsy[2-4] is acute ischemia followed by capillary injury, transudation, and constricting edema within the tough sheath inside the long bony canal of the facial nerve in the temporal bone. This process can lead to one of several possibilities: (1) neuropraxia—loss of function with axis cylinders intact; (2) axonotmesis—loss of function due to necrosis of axis cylinder; (3) a combination of both; or (4) a progression from neurapraxia to axonotmesis. If only neurapraxia is present, the chance for complete recovery is excellent, but it is important to know the exact condition of the nerve in order to afford the patient this prognosis.

Diagnosis

A great mistake can be made by labeling as Bell's palsy a patient with sudden facial paralysis,

Submitted August 27, 1971.

The Author

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Table 2. Eventual Recovery Compared With Nerve Excitability Tests on 24 Patients Who Originally Had Unimpaired Excitability

	Cases	Full Recovery	Distortion on Movement & Rest	Distortion on Movement	Untraced
Decreased response	15	10	3	0	2
Absent response	9	2	5	2	0

without first taking a history and examining the patient. A history of hearing loss, vertigo, aural discharge, recent external otitis, or hemifacial spasms is significant. It is important that x-ray studies of the mastoid be made, including, if possible, laminograms. Chronic mastoiditis with or without cholesteatoma, glomus tumors, and facial nerve tumors can mimic Bell's palsy. In addition, the author routinely does audiometry and vestibular testing to rule out involvement of the acoustic nerve.

A careful history is helpful in determining the level of involvement of the facial nerve. If a taste aberration is present, the chorda tympani nerve is involved. If loud noises are bothersome, the stapedius muscle is paralyzed, indicating that the tympanic segment is involved. In order to establish whether the labyrinthine and geniculate ganglion segments are involved, the Schirmer tear test is used. This is performed by placing a strip of absorbent paper between the lower lid and the eye and comparing the extent of tearing between the two eyes. Decreased tearing indicates involvement of these segments. Periauricular pain preceding the paralysis is important because it is *a poor prognostic sign.* In addition to establishing the nature of the paralysis, it is important to know the condition of the axons—whether there is neurapraxia, axonotmesis, or a combination of both. The single most reliable test and the one which gives the most recent state of the facial nerve is the nerve excitability test.[5] It has been demonstrated that even when the nerve is sectioned, nerve excitability does not deteriorate for three days, so it is extremely important to retest patients frequently. The fact that serial nerve testing is valuable in following initially unimpaired cases[6] is demonstrated in Table 2. Richardson[7] has related the significance of the results of the nerve excitability test to the extent of recovery of the patient with Bell's palsy (Table 3).

Table 3. Nerve Excitability Results (Richardson)

Nerve Excitability	Cases	Full Recovery	Incomplete Recovery Grade II	Grade III
Unimpaired	61	55 (90%)	4 (7%)	2 (3%)
Decreased	21	10 (48%)	9 (43%)	2 (9%)
Absent	35	7 (20%)	11 (31%)	17 (49%)

Medical Treatment

Since the primary cause of Bell's palsy is vasoconstriction, therapy should be directed toward this condition. Hilger[2] recommends intravenous procaine-nicotinic acid therapy in the hospital. An occasional neurapraxia case will have motor function restored temporarily during the infusion. The infusion is repeated three times daily and consists of 0.5 gm procaine and 50 mg nicotinic acid in 250 cc of 5 percent dextrose. The rate of infusion is adjusted to produce both a warming and mild numbness. Steroid therapy has its advocates and can be used. In addition, physiotherapy is important in order to keep the facial muscles from undergoing atrophy. Galvanic stimulation should be used three times weekly. Frequent facial massage is useful. The eye should be taped shut at night to prevent injury to the cornea. If there is decreased or absent tearing,

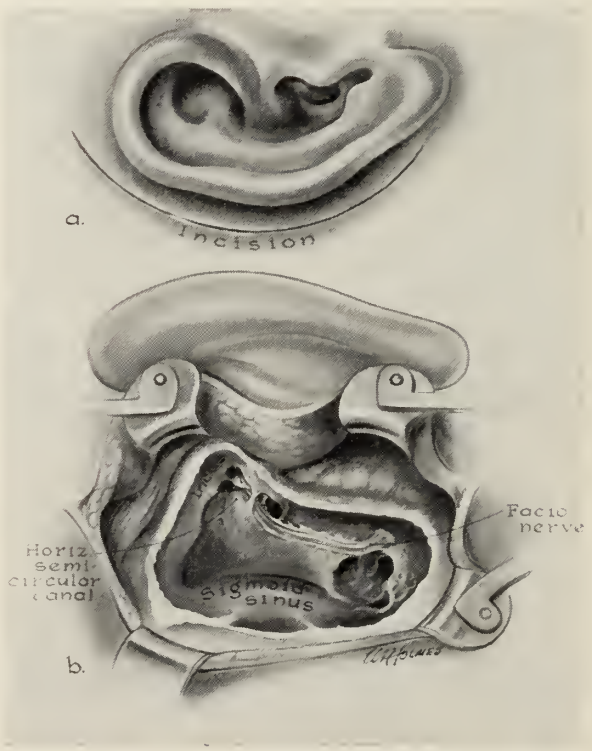


Fig. 1. Facial nerve decompression: (a) incision and (b) mastoidectomy completed, exposing facial nerve and anatomic relationships.

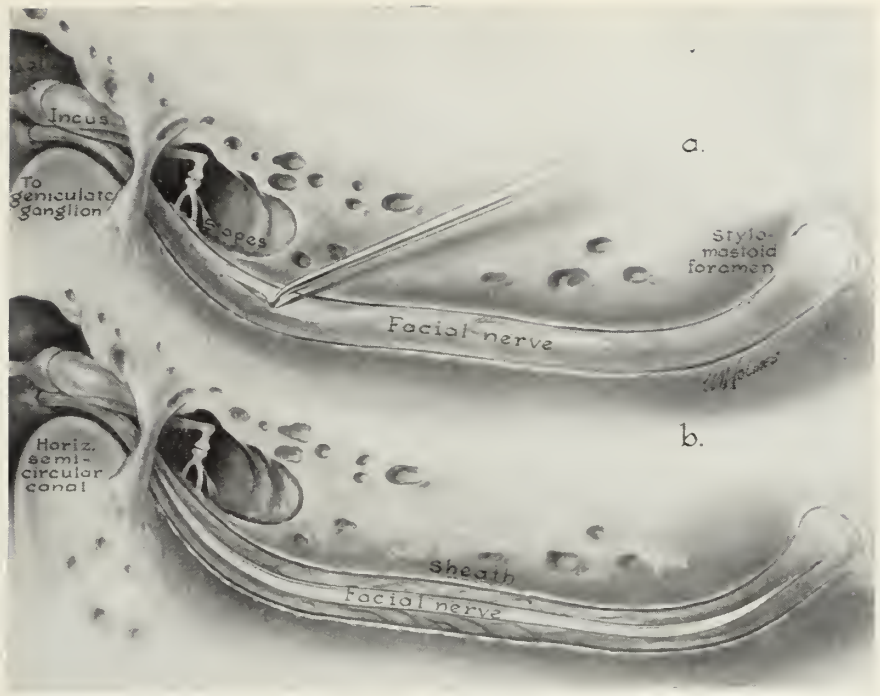


FIG. 2. Facial nerve decompression (continued): (a) Nerve completely exposed from stylomastoid foramen to geniculate ganglion. Beginning of sheath incision. (b) Sheath incised completely. Nerve totally decompressed.

artificial tears should be used to keep the eye moist.

Surgical Treatment

There is no argument that a facial nerve paralysis caused by acute mastoiditis, trauma, or cholesteatoma cries for emergency decompression "before the sun sets." Until the development of the nerve excitability test, the decision of when to decompress the facial nerve in Bell's palsy was, to say the least, muddled. This was due to several things: (1) Until Richardson[7] and Campbell,[6] no meaningful series of patients had been collected; (2) The hesitancy of the otologist to do a decompression. It is only recently that the facial nerve has been used extensively as a landmark in temporal bone surgery and its location established early in the course of surgery. Familiarity has reduced the stigma attached to decompression. (3) Lack of knowledge on the part of the medical profession that such an operation exists and who can do it. (4) The fact that a decompression from the stylomastoid foramen to the geniculate ganglion formerly meant that the patient would be left with a mastoid cavity and a hearing loss.

Thanks to modern otosurgical technics, the facial nerve decompression today can be done quickly and with no morbidity. The integrity of the ear canal and ossicular chain can be kept intact (Figs. 1 and 2). The patient can be discharged from the hospital on the second postoperative day.

There is no longer any doubt which case should have decompression and which should be treated medically. If there is no difference in nerve excitability between the two facial nerves, recovery should be prompt. If there is less than 3.5 milliampere difference between the two nerves, recovery should be expected, but frequent testing should be done. If there is no nerve excitability, if there is a difference of more than 3.5 milliampere, if there is a progressive worsening of the nerve excitability on the involved side, *decompression should be done as soon as possible*, whether the paralysis has been present one week, six weeks, or three months. Sheehy[8] reports two cases in which partial function returned immediately after decompression. If, according to the tear test, the labyrinthine segment of the facial nerve is involved and the indications for decompression are present, this may be done by the method indicated in Figure 3, after doing the standard decompression.

Summary

1. Only 55 percent of Bell's palsy patients recover completely. The remainder have either slight or severe deformities.

2. Since many diseases may mimic Bell's palsy, a thorough history and examination are

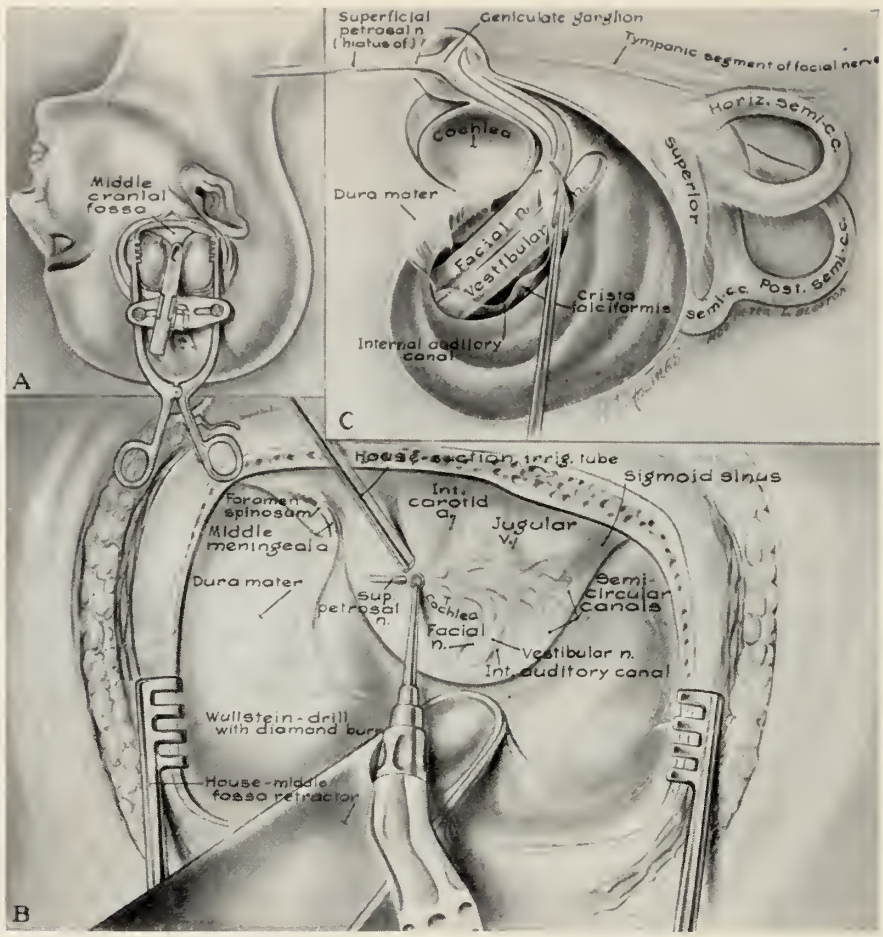


FIG. 3. Decompression of labyrinthine segment of facial nerve — middle fossa approach. (A) Bone plug removed. House middle fossa retractor in position. (B) Beginning dissection. Related structures in phantom. (C) Dissection complete. Sheath is incised. Note relationship of facial nerve to cochlea, vestibular nerve, and semicircular canals.

necessary, including mastoid x-ray films, audiometry, and electro-nystagmography.

3. The nerve excitability test should not only be used initially, but frequently during the course of the disease.

4. It is now possible to determine which patients will recover spontaneously and which patients need to be decompressed.

5. The decompression operation is a safe operation, leaving no obvious scar and no functional disability of the ear. It should be utilized more often.

Acknowledgment: Medical illustrations by William Holmes, Medical Illustrator, St. Lukes Hospital, Cleveland, Ohio.

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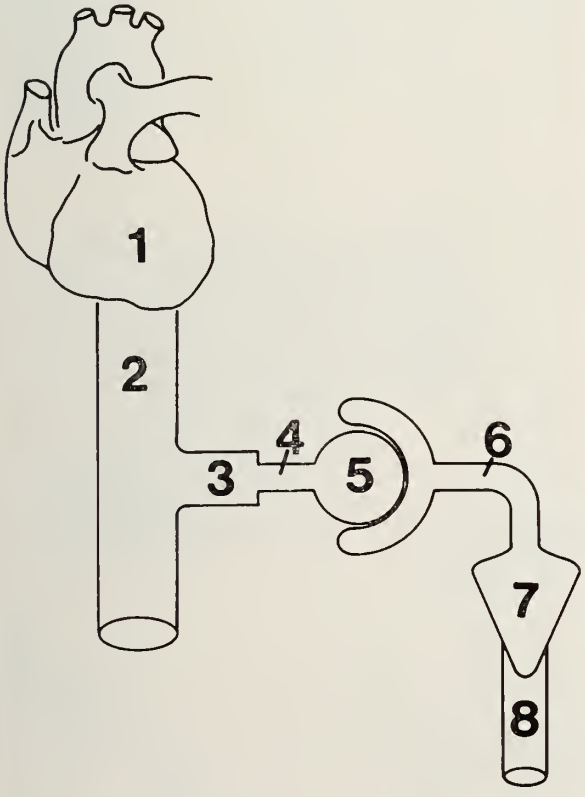
NEPHROLOGY

The Patient Who Makes No Urine

LEONARD B. BERMAN, M.D.*

ANURIA (OR SEVERE OLIGURIA) is an abrupt and dramatic clinical problem. The physician must think clearly and make all possible use of available data. Figure 1 can serve as an analytical framework in which to consider the possibilities. The numbered key locates the primary area of difficulty and lists some clinical examples. The fact that some of the problems are treatable and reversible demands the utmost care in diagnosis.

1	Heart	Shock
2	Aorta	Dissection, thrombosis, emboli
3	Main Renal Arteries	Same as #2, bilateral
4	Afferent Arterioles	Disseminated intravascular coagulation
5	Glomeruli	†Acute glomerulonephritis
6	Tubules	†Acute tubular necrosis
7	Papillae	Necrotizing papillitis
8	Ureters	Obstruction, bilateral



†Diagnostic clues may be in a very few drops of urine.

FIG. 1. Analytical framework for data indicated.

*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.

E.N.T. Case of the Month

ANDREW W. MIGLETS, JR., M.D.*

This 63-year-old woman presents with a gradually enlarging facial defect. In reviewing her records, we find that it has been present for at least ten years but has been gradually increasing in size.

Her past history is significant in that 20 years ago she had a left 5th nerve section for tic douloureux, which resulted in anesthesia of the upper two thirds of her face. Following this operation she had persistent paresthesia at the lower corner of her nose.



FIG. 1. This patient presents with a 20-year history of enlarging facial defect.

She admits to picking and scratching the lower aspect of her face (Fig. 1).

What is your initial diagnosis and plan of treatment?

(See p. 646 of this issue for further information and discussion.)

*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.

Submitted March 31, 1971.

Discussion of E.N.T. Case of the Month

(continued from p. 645)

The diagnosis was factitial dermatitis (a self-induced traumatic facial lesion). The paresthesia at the corner of the patient's nose resulting from the 5th nerve section caused her to pick and scratch at this area over a long period of time. In traumatizing the anesthetic area, a great deal of tissue damage was done, and over a 20-year period, the defect pictured was produced.

She later developed keratitis of her left eye, which required enucleation.

Our treatment intially consisted of multiple biopsies of the tissues in the area to rule out the possibility of other destructive lesions of the face, such as Wegener's granulomatosis or basal cell carcinoma. The biopsy reports showed only chronic inflammatory tissue.

Psychiatric evaluation revealed the patient stable enough to undergo surgical repair, which she wished very much to have done.

The nasal defect was closed with a transposition flap from her cheek (Fig. 2). The marked retraction of her upper lip remained, which we were unable to close primarily. This was repaired with an Abbe flap taken from her lower lip and rotated into the defect (Fig. 3). Her postoperative appearance is satisfactory, with the nasal defect closed and a fairly straight contour to her upper lip (Fig. 4).



FIG. 3. Upper lip defect closed utilizing flap of lower lip (Abbe flap).



FIG. 2. Nasal defect closed with cheek transposition flap.



FIG. 4. Postoperative result.

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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. Flattening of the T wave may be seen in EKG tracings.

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For Amebiasis. Adults: For acute intestinal amebiasis, 750 mg. orally three times daily for 5 to 10 days. For amebic liver abscess, 500 to 750 mg. orally three times daily for 5 to 10 days.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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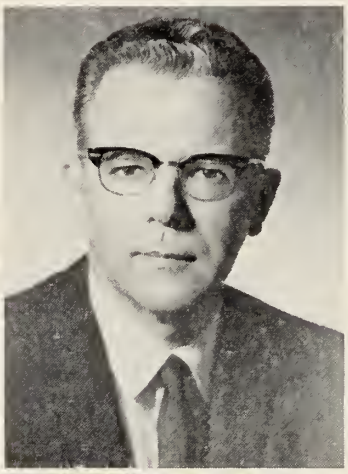
1972 Annual Meeting

Ohio State Medical Association

Cincinnati – May 8-11

Officers and Councilors Elected at the 1972 Annual Meeting

THE HOUSE OF DELEGATES of the Ohio State Medical Association at the 1972 Annual Meeting in Cincinnati installed into office the Incoming President, named a President-Elect, elected four new Councilors and reelected two Councilors. Following are brief biographical sketches of the President-Elect, the Incoming President, the new Councilors, with additional information about other members of The Council.



Oscar W. Clarke, M.D.

Dr. Oscar W. Clarke, of Gallipolis, was named President-Elect of the Association and will be installed as President at the 1973 Annual Meeting in Columbus. He is a practicing physician in Gallipolis, specializing in internal medicine and is a diplomate of the American Board of Internal Medicine. He is chief of internal medicine on the Holzer Medical Center Hospital staff, is vice-president of the staff, and a member of the Hospital's Board of Trustees.

In addition to his professional activities, he comes to the high office of the Association with a rich background of organization activities and accomplishments. He was first named to The Council as Councilor of the Ninth District in 1966. Since then he has been a member and chairman of the OSMA Auditing and Appropriations Committee, the OSMA Liaison Committee with the Ohio State Bar Association, the OSMA Scientific Exhibit Evaluation Committee, and the OSMA Advisory Committee to the Woman's Auxiliary.

Other statewide responsibilities include those as trustee of the Medical Advances Institute, as member of the OSMA Hospital Relations Committee, OSMA Workmen's Compensation Committee, OSMA Membership and Planning Committee, OSMA Joint Coordinating Health Planning Committee, and OSMA representative to the Professional Relations Committee with the Ohio Hospital Association. He was named by the House of Delegates as Alternate Delegate to the American Medical Association, effective in 1970, and was elected Delegate beginning in the current year.

He is a past president of the Gallia County Medical Society, a former trustee of the Central Ohio Heart Association, a past president of the Gallia County Heart Branch, and a former vice-president and former trustee of the Ohio Society of Internal Medicine. Dr. Clarke is a Fellow of the American College of Physicians, and a Fellow of the Royal Society of Medicine. He is a member of the American Heart Association, the American Federation for Clinical Research and the American Association for the Advancement of Science.

In civic and community affairs he has been equally active. Among positions of honor, he has been president of the Gallipolis City Board of Health, president of the local Rotary Club, president of the Tri-County Community Concert Association, and vice-president of the Tri-State Regional Council for Boy Scouts. He has been a director of the Community Improvement Corporation, a member of the local City Planning Commission, a member of several historical societies, art groups, and nature and outdoor organizations.

A native Virginian, he attended Randolph Macon College, and received his medical degree from the Medical College of Virginia in 1944. After an internship at Boston City Hospital and some residency training, he entered military service in the U. S. Air Force and was assigned as chief of medicine at a station hospital in Germany. Dr. Clarke is affiliated with several fraternal organizations and is an Elder in the First United Presbyterian Church of Gallipolis. He is married to the former Susan Frances King, and has three daughters and a grandson.

Incoming President

Dr. William R. Schultz, of Wooster, was installed as President of the Association at the final session of the House of Delegates and assumed office at that time. He was named President-Elect at the 1971 Annual Meeting in Columbus after serving six years on The Council as Councilor of the Eleventh District.



William R. Schultz, M.D.

His activities in the Wayne County Medical Society go back many years, and include many appointive as well as elective offices. For the term 1950-1951 he served as County Society president and since that time has served as a delegate from Wayne County to the OSMA House of Delegates.

In addition to his activities as a member of The OSMA Council, he has served the State Association in several other capacities— as a member of the OSMA Redistricting Committee, as chairman of the OSMA Hospital Relations Committee, as chairman of the OSMA Planning and Membership Committee, and as chairman of the OSMA Auditing and Appropriations Committee.

He has been active also in the organization work of his specialty. He is a member, former secretary-treasurer, and past president of the Cleveland Otolaryngology Club, and a member of the Akron Academy of Ophthalmology and Otolaryngology.

He is a member of the Board of Directors of the Wooster Community Hospital, a member of the Advisory Council, Seven County Regional Health Planning Board, member of the Corporation Boys Village, member of the Board of Trustees of Blue Cross of Northeast Ohio, and member of the Physicians Advisory Committee of the same organization.

In civic activities, he is a member and past president of the Wooster Rotary Club, a member and past president of the Wooster City Board of Education, and a past president of the Wayne County Mental Hygiene Association. Also, he is a former director and vice-president of the Wooster Chamber of Commerce, and former crusade chairman of the Wayne County Chapter of the American Cancer Society.

Other organizations to which he belongs are the Izaak Walton League, the American Forestry Association, Phi Chi Fraternity, of which he is a chapter past president, OMPAC, and the Ohio Committee for Voluntary Health Planning, of which he is chairman.

During World War II, Dr. Schultz was in active service with the Army Medical Corps from 1942 to 1946. Assignments included those on the otolaryngology service of the 70th General Hospital, and as chief of surgery for the 5th Medical Dispensary. He attained the rank of major in the AUS.

Dr. Schultz was born in Streator, Illinois. He received an A.B. degree from the College of Wooster in 1933, and his M.D. degree from George Washington University School of Medicine in 1939. His internship was at the Medical Center of the University of Pittsburgh, with residency training at Barnes Hospital, St. Louis.

The family includes his wife, Helen (Speer), a son, William Richard, and a daughter, Margaret. A second son, Harvey, is deceased.

First District Councilor

The House of Delegates elected Dr. Stephen P. Hogg, of Cincinnati, as Councilor of the First District to succeed Dr. Paul N. Ivins, of Hamilton, who had served the maximum of three terms as District Councilor.

Dr. Hogg is in private practice, specializing in the ear, nose and throat field. He is a diplomate of the American Board of Otolaryngology and is associate clinical professor of otolaryngology at the University of Cincinnati College of Medicine.

He is the immediate past president of the Academy of Medicine of Cincinnati and has served as the Academy's delegate to OSMA. He is also active in the organization work of his specialty, being a past president of the Cincinnati Otolaryngology Society and a past president of the Ohio State Otolaryngology Society.

In the related medical-health fields, he is president of the Midwest Foundation for Medical Care, vice-president of the Regional Association of County Medical Societies, and a member of the Board of Trustees of the Health Planning Association of the Central Ohio River Valley. He is a member of the Board of Trustees of Medical Advances Institute, a member of the Board of Trustees of Health Resources Coordinating Center, chairman of the Medical Advisory Committee of Blue Cross of Southwest Ohio and ex-officio

member of the Board of Trustees of the same organization.

Dr. Hogg is on the attending staffs of Cincinnati General, Children's, Christ, and Bethesda Hospitals, and on the courtesy staffs of Deaconess and Good Samaritan Hospitals.



Stephen P. Hogg, M.D.

He is a native of Jackson, Ky., received his bachelor's degree from the University of Kentucky, and earned his M.D. degree from the University of Louisville in 1944. He took his internship at the U. S. Naval Station, Pearl Harbor, as part of his tour of active service with the Navy. Residency training in otolaryngology was at the University of Cincinnati College of Medicine and Cincinnati General Hospital.

Dr. Hogg is a member of the Rotary Club, and an elder and member of the Session of the Knox Presbyterian Church, Cincinnati. He is married and has six children.

Third District Councilor

The House of Delegates elected Dr. John C. Smithson, of Findlay, as Councilor of the Third District to succeed Dr. Dwight L. Becker, of Lima, who had served four years on The Council and was not a candidate for reelection.

Dr. Smithson is a native of Findlay and has served most of his professional career there, where he is in the private practice of internal medicine. He is a Fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

An active participant in medical and health organization work, Dr. Smithson is a past president of the Hancock County Medical Society and has served as the local society's delegate to the OSMA for a number of terms. Among activities on the state level, he has been a member of the OSMA Committee on Legislation. He has been active in, and is a former president of the Northwest Ohio Medical Association, one of the oldest and most active district societies in Ohio.



John C. Smithson, M.D.

Dr. Smithson received both his bachelor's and medical degrees from the University of Michigan, the latter in 1952. He took his internship at King County Hospital, Seattle, Wash., and returned to University Hospital at Ann Arbor for his residency training in internal medicine.

He is affiliated with the Blanchard Valley Hospital in Findlay and is former chief of the medical staff there. He is a member of the American Medical Association, a member of the Board of Trustees of the Central Ohio Heart Association, a member of the board of the Greater Ottawa Valley Comprehensive Health Planning Association, a member of Heart Advisory Committee of the Northwest Ohio Regional Medical Program, a member of the Advisory Board of the Hancock County Home Health Nursing Association, and a member and former trustee of the Hancock County United Community Fund.

The Smithson family includes his wife Mary and five children. The family church is the Trinity Episcopal Church, of Findlay.

Seventh District Councilor

The House of Delegates elected Dr. Robert E. Rinderknecht, of Dover, as Councilor of the Seventh District to succeed Dr. Sanford Press, of Steubenville. Dr. Press had served the maximum number of terms on The Council and was not eligible for reelection.

Dr. Rinderknecht is a practicing physician in the Dover area, specializing in internal medicine and cardiology. He is Fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

He comes to the Councilor position after a number of offices of responsibility in medical or-

ganization work. He returned to his native town to practice in 1951 and immediately became a member of the Tuscarawas County Medical Society and OSMA. Ten years later he served as president of the County Society. From 1960 to the current year he has served as delegate to the OSMA House of Delegates, and in addition has been a member of the OSMA Legislative Committee from 1963 to the present.



R. E. Rinderknecht, M.D.

Among other professional affiliations, he is a member of the American Heart Association, a member of the Board of Trustees of the Ohio Affiliate of AHA, and a past president of both the Tuscarawas County Heart Branch and the Heart Association of East Central Ohio. He is a member of the American Society of Internal Medicine, a member and former trustee of the Ohio Society of Internal Medicine and a former delegate to the ASIM. He is also a diplomate member of the Pan American Medical Association, and a member of OMPAC and AMPAC.

Dr. Rinderknecht received his bachelor's degree from Adelbert College, Western Reserve University in 1943 and his M.D. degree from Western Reserve University School of Medicine in 1945. A rotating internship followed at Grasslands Hospital, Valhalla, N.Y.

A tour of active duty in the Army Medical Corps came next and in 1948 he was separated from service with the rank of captain. Some four years of residency training in internal medicine followed at University Hospitals, Cleveland, and the Veterans Administration Hospital, also in Cleveland.

Dr. Rinderknecht is active in his local church and in several fraternal organizations. He is a member, and served on the Board of Elders, of the First Moravian Church of Dover. He is a member of the Tuscarawas Blue Lodge of Masons in Dover, a member of the Scottish Rite, Valley of Canton, and the Tadmore Shrine, Akron, being the medical director for the latter.

He is also a member of the Elks Lodge and Nu Sigma Nu Fraternity.

Dr. Rinderknecht is married to the former Janice Rausch and has three children — Mary Ellen (Mrs. Kevin Adams), William A., a premedical student at Miami University, and Janis E. His office is at 404 North Walnut Street, Dover 44622, and the home address is 7 Parkview Drive, Dover 44622.

Ninth District Councilor

The House of Delegates elected Dr. Thomas W. Morgan, of Gallipolis, as Councilor of the Ninth District to succeed Dr. Clarke.

Dr. Morgan is a practicing surgeon in Gallipolis, associated with the Holzer Medical Center Clinic. He is a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. Currently he is assistant clinical professor of surgery, Ohio State University College of Medicine, Columbus.



Thomas W. Morgan, M.D.

He has been a member of the OSMA House of Delegates, as delegate from the Gallia County Medical Society for a number of terms, has served on several Resolutions Committees of the House, and was chairman of the Committee on Nominations. In addition, he has served as chairman of the OSMA Committee on Disaster Medical Care, and as a member of the OSMA Committee on Governmental Medical Care Programs.

He is a past president of the Gallia County Medical Society and has served the local organization in many ways in addition to being its delegate.

His activities in the American College of Surgeons have been equally impressive. He was chairman for several years of the Ohio Committee on Trauma, ACS, and is currently chief of Section V, of the Committee on Trauma, ACS, a section

that includes Ohio, Michigan, Indiana, Illinois (including Chicago), Wisconsin and Minnesota. In addition, in 1971 he was elected to the National Committee on Trauma.

In 1971 he was named chairman of the State Advisory Committee, ACS. He is also a member of the Central Ohio Credentials Committee of ACS.

In the Ohio Chapter of the American College of Surgeons he has served as councilor of the Southeast Ohio area, and as president-elect and president.

Dr. Morgan graduated Summa Cum Laude from Washington and Jefferson College, and received his medical degree from Harvard in 1945. After an internship at Peter Bent Brigham Hospital, Boston, he served a tour of active duty in the Army Medical Corps during the World War II period. Residency training followed at Ohio State and he became chief resident surgeon in 1952. In that same year, after writing a thesis entitled "An Experimental Evaluation of the Billroth I Operation with Vagotomy," under the direction of Dr. Robert M. Zollinger, he was given a degree of Master of Medical Science in Surgery. An article on this same subject was published in the *Surgical Forum.*

Dr. Morgan has also written articles that appeared in *Surgery,* the *American Surgeon,* and one, the "Practical Aspects of Potassium Therapy in the Surgical Patient," that appeared in the *Ohio State Medical Journal,* September 1951.

Other fraternal and professional societies with which he is associated are Beta Theta Phi (president of Washington and Jefferson Chapter), Phi Beta Kappa, the Aesculapian Club of Boston, American Medical Association, Pan American Medical Association, Robert M. Zollinger Club, and the Pan-Pacific Surgical Association.

He also is associated with numerous non-professional organizations and activities. He is a former vice-president of the Ohio Valley Health Services Foundation, a member of the Board of Directors of the Gallipolis Chamber of Commerce, is associated with several Masonic bodies, and the Elks Lodge. In 1964 he was a delegate to the Republican National Convention. He sings in a barbershop quartette and has won the *Medical Tribune's* Auto Safety Award and the Buckeye Sheriffs Association Award of Merit.

Other Members of The Council

Dr. P. John Robechek, of Cleveland, as Immediate Past President, will continue to serve on The Council for another year.

Dr. David Fishman, of Cleveland, was reelected Councilor of the Fifth District, and Dr. Robert G. Thomas, of Elyria, was reelected Councilor of the Eleventh District.

Councilors in the midst of two-year terms are Dr. James G. Tye, Dayton, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Maurice F. Lieber, Canton, Sixth District; Dr. William M. Wells, Newark, Eighth District; and Dr. James C. McLarnan, Mt. Vernon, Tenth District.

Dr. James L. Henry, Grove City, is serving his second three-year term as Secretary-Treasurer.





These two views of the House of Delegates show the policy-making body of the Association in action. Two sessions were held — the first on Monday morning of the Annual Meeting week and the other on Thursday morning, running into the afternoon. Between these sessions, Reference Committees heard discussions by interested persons and reported their recommendations back to the House.



Three key officers of the Association were caught chatting during the Annual Meeting. They are, from left, Dr. William Schultz, Incoming President; Dr. John Robechek, Outgoing President; and Dr. Oscar Clarke, President-Elect.

Index to Actions on Resolutions

Report of Resolutions Committee No. 1 begins on page 666

Resolutions Committee No. 2, page 669

Resolutions Committee No. 3, page 677

Resolutions Committee No. 4, page 684

Resolution No. . .	Subject and Sponsor	Referred to Resolutions Committee No. . .
1	Peer Review, PRSO (Delaware County Medical Society)	No. 1
2	Peer Review, PRSO (Ross County Medical Society)	No. 1
3	Notice to County Medical Societies in Re of Legislative Action (Academy of Medicine of Cincinnati)	No. 3
4	Local Review by Local Physicians (Academy of Medicine of Cincinnati)	No. 1
5	Report on Implementation on Resolutions Passed by the House of Delegates of the Ohio State Medical Association (Academy of Medicine of Cincinnati)	No. 3
6	Recognition for the Association of County Medical Executives, Inc. (ACME) (Academy of Medicine of Cincinnati)	No. 3
7	Change in OSMA Bylaws (Council of the Ohio State Medical Assn.)	No. 3
8	Liaison with Medical Board (Academy of Medicine of Cincinnati)	No. 4
9	Proposed Solution to Current Malpractice Problems (Academy of Medicine of Cincinnati)	No. 4
10	Attorney's Contingency Fees in Relation to Current Malpractice Problems (Academy of Medicine of Cincinnati)	No. 4
11	Medical Advances Institute (Delaware County Medical Society)	No. 1
12	Funding of Comprehensive Health Plans (Academy of Medicine of Cleveland)	No. 2
13	Medicare Part B (Academy of Medicine of Cleveland)	No. 2
14	Policy Statement on Alcoholism (Academy of Medicine of Cleveland)	No. 4
15	Grass Roots Involvement in AMA (Academy of Medicine of Cleveland)	No. 3
16	Peer Review by Component Societies (Academy of Medicine of Cleveland)	No. 1
17	Closed Panel or Prepaid Group Practice (Academy of Medicine of Cleveland)	No. 2
18	Commending The Council of the OSMA (Academy of Medicine of Cleveland)	No. 1
19	Honorary Membership Nomination (not referred) (Council of the Ohio State Medical Assn.)	
20	Medical Advances Institute (Mahoning County Medical Society)	No. 1
21	Review of O.M.I., Inc., Coverages (Defiance County Medical Society)	No. 2
22	Annual Chest X-ray Exams (Defiance County Medical Society)	No. 4
23	Invoice for Health Care Under Medical Assistance Program (Trumbull County Medical Society)	No. 2
24	Exposure of Failure of Government Medical Programs (Richland County Medical Society)	No. 2
25	Proposed Amendment to the Bylaws of the Ohio State Medical Association (Delegates Joseph Bonta, M.D., Columbus and Thomas Morgan, M.D., Gallipolis)	No. 3
26	Medical Advances Institute (Richard E. Hartle, M.D., Delegate, Fairfield County Medical Society)	No. 1
27	Ohio Welfare Department Forms (Delegates, Second Councilor District)	No. 2
28	Reaffirm Autonomy in all Peer Review Activities (Columbiana County Medical Society)	No. 1
29	Medicare and Medicaid (Huron County Medical Society)	No. 2
30	Assessment for Preservation of Constitutional Rights (Huron County Medical Society)	No. 3
31	Involuntary Servitude (Huron County Medical Society)	No. 3
32	H.R. 7182 (Huron County Medical Society)	No. 1
33	Medical Advances Institute (Huron County Medical Society)	No. 1
34	Health Care — Negotiable Services (Huron County Medical Society)	No. 2
35	Liberty to Contract (Huron County Medical Society)	No. 2
36	Average Length of Stay (Huron County Medical Society)	No. 1
37	Nationwide Educational Campaign (Huron County Medical Society)	No. 3
38	AMA Reorganization (Council of the Lake County Medical Society)	No. 3

Resolution No. . .	Subject and Sponsor	Referred to Resolutions Committee No. . .
39	**Unit Rule** (Council of the Lake County Medical Society)	No. 3
40	**Phase II** (Council of the Lake County Medical Society)	No. 2
41	**H.R. 7182** (Council of the Lake County Medical Society)	No. 1
42	**H.M.O.'s** (Council of the Lake County Medical Society)	No. 2
43	**Medical Advances Institute** (Council of the Lake County Medical Society)	No. 1
44	**Regional Medical Programs** (Council of the Lake County Medical Society)	No. 2
45	**Capitation (and Ethics)** (Council of the Lake County Medical Society)	No. 2
46	**Dissolution of the American Board of Nuclear Medicine** (James Tye, M.D., Dayton (on behalf of the Radiologists) and R. G. Thomas, M.D., Elyria (at the request of the Ohio Society of Pathologists)	No. 3
47	**Homicide by Handguns** (Academy of Medicine of Toledo and Lucas Co.)	No. 4
48	**Development and Comparison of Improved Health Care Systems** (Academy of Medicine of Toledo and Lucas Co.)	No. 2
49	**H.R. 1** (C. G. Madsen, Jr., M.D., Delegate, Lake County Medical Society)	No. 1
50	**Waiver of OSMA Dues at Age 80** (Felix A. Pesa, M.D., Delegate, Mahoning County Medical Society)	No. 3
51	**Non-Therapeutic Use of Drugs by Athletes** (Delegation, Academy of Medicine of Columbus and Franklin County)	No. 4
52	**Phenylketonuria** (Madison County Medical Society)	No. 4
53	**Scotochromogen** (Madison County Medical Society)	No. 4
54	**VDRL** (Madison County Medical Society)	(withdrawn at first session)
55	**Hospital Board** (Madison County Medical Society)	No. 3
56	**Relative Value Fee Schedule** (Allen County Academy of Medicine)	No. 1
57	**Per Diem for Delegates** (Summit County Medical Society)	No. 3
58	**1973 Annual Meeting** (Summit County Medical Society)	No. 3
59	**Health Maintenance Organizations** (Summit County Medical Society)	No. 2
60	**Critical Need to Reevaluate Available Resources to Support Hospital-Based Training Research and Educational Programs** (Frederick P. Osgood, M.D., Delegate, Academy of Medicine of Toledo and Lucas County)	No. 3
61	**Revocation of O.M.I. Utilization Review Program** (Stark County Medical Society)	No. 2
62	**O.M.I., Inc. "Hold Harmless" Position** (Stark County Medical Society)	No. 2
63	**O.M.I. "Hold Harmless"** (Huron County Medical Society)	No. 2
64	**Withdrawal of O.M.I. from National Association of Blue Shield Plans** (Stark County Medical Society)	No. 2
65	**Special A.M.A. Open Hearings** (By the Fourth District)	No. 3
66	**Report of Ad Hoc Committee on Health Care Delivery (Model Medical Care Foundation)**	No. 2
67	**Continuing Medical Education Report**	No. 3

Note: This index is for reference purposes only, and is not a part of the Official Proceedings of the House of Delegates.

Proceedings of the House of Delegates 1972 Annual Meeting

MINUTES OF FIRST SESSION

THE FIRST SESSION of the House of Delegates of the Ohio State Medical Association was convened at 9 a.m., Monday, May 8, 1972 at the Cincinnati Exposition Center, Cincinnati, with President P. John Robechek, Presiding.

The Invocation was offered by the Rev. Ernest Bigelow of Cincinnati.

Dr. Milton W. Gwinner, President of the Academy of Medicine of Cincinnati and Hamilton County welcomed the delegates and guests to Cincinnati.

Dr. C. A. Hoffman, Huntington, W.Va., President-Elect of the American Medical Association brought greetings from the AMA and addressed the House of Delegates.

Report on Delegates Present

Dr. H. William Porterfield, Franklin County, Chairman of the Credentials Committee, reported 159 delegates seated and eligible to vote. A number of alternate-delegates, guests, officers of county medical societies, and executive secretaries were in attendance.

1971 Minutes Approved

The minutes of the 1971 sessions of the House of Delegates, as published in the July, 1971, issue of The Ohio State Medical Journal, were approved by official action.

Introduction of Guests

Dr. Robechek introduced the following honored guests:

Dr. Sanford S. Scheingold, Cincinnati, Vice President, Ohio Dental Association; Mr. Elbert W. Jones, Zanesville, Chairman of the Board, Ohio Hospital Association; Miss Ruth Ann Busald, Cincinnati, President, Ohio Nurses Association; Dr. Layton S. Shaffer, Columbus, President, Ohio Osteopathic Association of Physicians and Surgeons; Myron W. Ulrich, Esq., Cleveland, President, Ohio State Bar Association; Mr. Ed Briner, Massillon, President-Elect, Ohio State Pharmaceutical Association; Dr. Charles Miller, Crestline, President, Ohio Veterinary Medical Association; Dr. Lauren M. Brown, Akron, President, Ohio Academy of Family Physicians; Mrs. Judith Lowe, Worthington, President, Ohio State Society of Medical Assistants; Mrs. Russell L. Wiessinger, Lima, President, Woman's Auxiliary to the Ohio State Medical Association; Mrs. L. A. Loria, Bristolville, President-Elect, Woman's Auxiliary to the Ohio State Medical Association; Dr. Frances K. Harding, Columbus, President, American Medical Women's Association; Dr. Edmund C. Casey, Cincinnati, President-Elect, National Medical Association; Mr. Richard Sims, Columbus, Executive Secretary, Ohio Osteopathic Association of Physicians and Surgeons; Mr. Russell W. H. Kridel, Cincinnati, President, SAMA Chapter, University of Cincinnati College of Medicine; Dr. Robert Zipf, Dayton, Chairman, OSMA Committee on Scientific Work; Mr. James Imboden, Columbus, AMA Field Representative for Ohio and surrounding states; Mr. James E. Pohlman, Columbus, OSMA Legal Counsel; Dr. Frank L. Shively, Dayton, Chairman, OMI Board; Dr. Don E. Wood, Indianapolis, Indiana, AMA Board of Trustees and Dr. John Budd, Cleveland, AMA Board of Trustees and Mr. Richard Pine, Cleveland, President, Case Western Reserve University School of Medicine.

OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Richard L. Meiling, Columbus; Dr. Robert S. Martin, Zanesville; Dr. Frank H. Mayfield, Cincinnati; Dr. George W. Petznick, Cleveland; Dr. Horatio T. Pease, Wadsworth; Dr. Robert E. Tschantz, Canton; Dr. Henry A. Crawford, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton, Dr. Robert N. Smith, Toledo; and Dr. Richard L. Fulton, Columbus.

Also introduced were former members of the Council: Dr. Philip B. Hardymon, Columbus; Dr. J. P. McAfee, Portsmouth, Dr. Frederick T. Merchant, Marion; Dr. Paul F. Orr, Perrysburg; and Dr. George J. Schroer, Fort Loramie.

Report of Woman's Auxiliary President

Mrs. Russell L. Wiessinger, Lima, President of the Woman's Auxiliary to the Ohio State Medi-

cal Association was escorted to the podium by Dr. Dwight L. Becker, Lima, Third District Councilor. Mrs. Wiessinger reported on Auxiliary activities during her administraton and asked for closer physician-auxiliary ties. (See text of report, page 699).

Defiance County Presents $1,000 for AMA-ERF

Dr. Paul Brose, Delegate, from Defiance County presented to Dr. Philip Hardymon, Chairman, Ohio Committee on AMA-ERF, a $1,000 check for AMA-ERF which was specifically earmarked for the Medical College of Ohio at Toledo.

AMA-ERF Checks Presented

The following representatives of Ohio's Medical schools received American Medical Association Education and Research Foundation checks from Dr. Philip B. Hardymon, Chairman of the Ohio Committee for the American Medical Association's Education and Research Foundation.

Dr. David Fishman for Case Western Reserve University School of Medicine, Cleveland. (Check for $10,688.83)

Dr. John A. Prior, Dean, The Ohio State University, College of Medicine, Columbus. (Check for $13,693.57)

Dr. Clifford G. Grulee, Jr., Dean, University of Cincinnati College of Medicine, Cincinnati. (Check for $19,121.94)

Dr. Howard Madigan, Associate Dean for Continuing Education, Medical College of Ohio at Toledo. (Check for $6,586.54)

Award for Volunteer Service in Vietnam

Under the project Vietnam Volunteer Program, sponsored by the American Medical Association, Dr. Hilaire Gaudreault, Hinckley, was awarded a certificate in recognition of meritorious service performed for the medical profession, the United States Government and the people of South Vietnam.

Presentation of Distinguished Service Citations

Dr. Charles A. Doan, Columbus, Dean Emeritus, College of Medicine, Ohio State University and Dr. Frederick T. Merchant, Marion, Past President, Ohio State Medical Board, and Past President, National Federation of State Licensing Boards, received from Dr. Robechek the distinguished service citation in recognition of their outstanding contributions to Ohio medicine. Dr. Doan and Dr. Merchant addressed the House of Delegates. (The text of the citations to Dr. Doan and Dr. Merchant appear on pages 700 and 701.)

Presentation of Special Award

Dr. Robechek presented to Dr. Glidden L. Brooks (formerly Toledo) of the Lemuel Shattuck Hospital, Boston, Massachusetts a special award for his service in connection with the Medical College of Ohio at Toledo and the Ohio State Medical Association Commission on Education. The Council of the Ohio State Medical Association unanimously voted to award Dr. Brooks this special award.

Certificates of Appreciation

The following received certificates of appreciation for their service to the Association: Dr. Richard L. Fulton, Columbus; Dr. Paul N. Ivins, Hamilton; Dr. George J. Schroer, Fort Loramie and Dr. Sanford Press, Steubenville as retiring members of the Council; Dr. Philip Hardymon, Columbus as retiring OSMA Delegate to the AMA; Dr. Glidden L. Brooks (formerly Toledo), Boston, Massachusetts as Chairman of the Committee on Education.

The following retiring members of Standing Committees: Dr. Roland L. Kennedy, Toledo (not present) Committee on Scientific Work; Dr. Carl W. Koehler, Cincinnati, (not present) Committee on Judicial and Professional Relations); Dr. Clyde G. Chamberlin, Hamilton (not present) Committee on Public Relations.

The following retiring chairmen of special committees were presented with certificates of appreciation: Dr. Richard L. Fulton, Columbus, Ohio Medical Indemnity Liaison Committee; Dr. Oscar W. Clarke, Gallipolis, Committee on Auditing and Appropriations; Dr. Arthur G. James, Columbus (not present) Committee on Cancer; Dr. Clyde O. Hurst, Portsmouth, (not present) Committee on Workmen's Compensation; Dr. Paul N. Ivins, Hamilton, Council on Fee Review Committee; and Woman's Auxiliary Advisory Committee; Dr. William R. Schultz, Wooster, Committee on Membership and Planning; and Committee for Voluntary Health Planning.

Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates—H. William Porterfield, Franklin County, Chairman; Marvin McClellan, Hamilton County; Thomas F. Moriarty,

Henry County; Robert Elliott, Hardin County; L. J. DeFreest, Summit County.

President's Address — Richard L. Fulton, Franklin County, Chairman; Kenneth W. Clement, Cuyahoga County; Robert P. Johnson, Butler County; Emil J. Meckstroth, Erie County.

Tellers and Judges of Election—E. Peter Coppedge, Jr., Cuyahoga County, Chairman; Philip T. Doughten, Tuscarawas County; John E. Albers, Hamilton County; F. Miles Flickinger, Allen County; A. Burton Payne, Lawrence County; Philip H. Taylor, Franklin County.

Resolutions Committee No. 1—Robert R. Clark, Summit County, Chairman; John J. Gaughan, Cuyahoga County; William J. Lewis, Montgomery County; Stephen P. Hogg, Hamilton County; John C. Smithson, Hancock County; Harry C. Mack, Lucas County; Robert E. Rinderknecht, Tuscarawas County; Walter B. Devine, Muskingum County; Thomas W. Morgan, Gallia County; John N. Meagher, Franklin County; James T. Stephens, Lorain County.

Resolutions Committee No. 2—William V. Trowbridge, Cuyahoga County, Chairman; Roland A. Gandy, Jr., Lucas County; Foster J. Boyd, Clinton County; Jerry L. Hammon, Miami County; Paul E. Lyon, Marion County; C. Edward Pichette, Mahoning County; Paul Mastros, Jefferson County; Gregory B. Krivchenia, Washington County; Harry Nenni, Lawrence County; Joseph A. Bonta, Franklin County; A. Burney Huff, Wayne County.

Resolutions Committee No. 3—Jasper M. Hedges, Pickaway County, Chairman; Milton W. Gwinner, Hamilton County; George J. Schroer, Shelby County; John A. Glorioso, Allen County; Benjamin H. Reed, Jr., Fulton County; Clarence L. Huggins, Cuyahoga County; Edward E. Grable, Stark County; Robert R. Johnson, Coshocton County; James A. L. Toland, Guernsey County; John W. Zimmerly, Jackson County; Robert W. Jones, Richland County.

Resolutions Committee No. 4—Homer A. Anderson, Franklin County, Chairman; Thomas E. Fox, Warren County; William G. Cassel, Montgomery County; Robert S. Oyer, Auglaize County; William H. Roberts, Wood County; Wesley J. Pignolet, Lake County; Rocco Antenucci, Summit County; German Ortiz, Belmont County; Irving A. Nickerson, Licking County; Roger P. Daniels, Meigs County; Richard W. Avery, Medina County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District—Charles D. Feuss, Jr., Hamilton County.

Second District—Isador Miller, Champaign County.

Third District—Walter A. Daniel, Seneca County.

Fourth District—C. Douglass Ford, Lucas County.

Fifth District—Joseph L. Bilton, Cuyahoga County.

Sixth District — William A. White, Stark County.

Seventh District—Carl A. Lincke, Carroll County.

Eighth District—Richard E. Hartle, Fairfield County.

Ninth District—James P. McAfee, Scioto County.

Tenth District—Joseph A. Bonta, Franklin County.

Eleventh District—William R. Graham, Huron County.

Dr. Robechek then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the committee this year would be the delegate from the Tenth District, Dr. Joseph A. Bonta, Franklin County.

President's Address

Mr. Page then introduced President P. John Robechek, Cleveland, who delivered his Presidential Address. (Text of the address appears on page 691).

Introduction of Representatives of other State Societies

Dr. Robechek introduced the following out-of-state presidents, each of whom addressed the House of Delegates; Dr. George P. Rosemond, President, Pennsylvania Medical Society; Dr. Harry S. Weeks, Jr., President, West Virginia State Medical Association.

Also introduced were: Dr. Don E. Wood, Board of Trustees, AMA and Mr. Warren Tryloff,

Executive Director, Michigan State Medical Society, East Lansing, Michigan.

Introduction of Resolutions

Dr. Robechek then called for the introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting could be introduced by a mere reading of the title only. Sixty-four resolutions plus reports from the Ad Hoc Committee on Health Care Delivery and from the Commission on Medical Education were introduced and were referred to the resolutions committees.

RESOLUTION NO. 19-72

Honorary Membership Nomination
(Council of the Ohio State Medical Association)

The House of Delegates then voted to suspend the rules and act immediately on Resolution No. 19-72 without referral to a resolutions committee. Resolution No. 19-72 was unanimously adopted as follows:

WHEREAS, The Constitution and Bylaws of the Ohio State Medical Association were revised in 1970 to include the classification of Honorary Membership; and

WHEREAS, The House of Delegates may elect as an Honorary Member, any person distinguished for his services or attainments in medicine or the allied sciences or who has rendered other services of unusual value to medicine; and

WHEREAS, Mr. Charles H. Coghlan as Chief Executive Officer of Ohio Medical Indemnity, Inc. since its inception in 1945 has given dedicated service and leadership until his retirement July 1, 1972; THEREFORE, BE IT

RESOLVED, That the 1972 House of Delegates of the Ohio State Medical Association confer Honorary Membership upon Mr. Charles H. Coghlan.

Dr. Frank Shively, Jr., Dayton escorted Mr. and Mrs. Charles H. Coghlan to the rostrum. Mr. Coghlan addressed the House.

Withdrawal of Resolution No. 54-72

Dr. Sol Maggied, Delegate, Madison County, requested on behalf of Madison County Medical Society that Resolution No. 54-72, entitled VDRL, be withdrawn.

Emergency Resolution Presented

Dr. Robechek then called for the presentation of emergency resolutions. A resolution entitled "Special A.M.A. Open Hearings" received the required two-thirds vote of the delegates present to be considered by the House.

EMERGENCY RESOLUTION NO. 65-72

Special A.M.A. Open Hearings
(By the Fourth District)

WHEREAS, The purpose of the special open hearings to be conducted by the Long Range Planning Council of the A.M.A. is to allow free expression and criticism of the Constitution and Bylaws, the organizational structure, and the committee responsibilities of the American Medical Association, and

WHEREAS, The rules of procedure adopted by the Long Range Planning Council for the conduct of the hearings restrict free and spontaneous testimony, THEREFORE BE IT

RESOLVED, That (A.) The House of Delegates of the Ohio State Medical Association recommends that the procedures used for the hearings by the Long Range Planning Council as directed by substitute Resolution 50 (American Medical Association Clinical Meeting 1971) be the same as those used by a resolutions committee of the House of Delegates of the American Medical Association, and BE IT FURTHER

RESOLVED, That (B.) This resolution be transmitted promptly to the Executive Vice-President of the American Medical Association, the Speaker of the A.M.A. House of Delegates and through them to the Long Range Planning Council of the American Medical Association.

Richard L. Meiling, M.D., chairman of the Long Range Planning Council of the AMA was granted the privilege of the floor to discuss the work of the Council.

House Recessed

The House then recessed until the final session, Thursday morning, May 11.

MINUTES OF THE FINAL SESSION

The final business session of the House of Delegates convened at 9 a.m., Thursday, May 11, at the Cincinnati Exposition Center.

The following guests were introduced by President Robechek: Dr. John S. Harter, Louisville, Kentucky, President of the Kentucky Medical Association; Dr. Peter R. Petrich, Attica, Indiana, President, Indiana State Medical Association; and Dr. Sidney Adler, Detroit, Michigan, President, Michigan State Medical Society; Dr. Harry H. Fox, Cincinnati, Chairman of the 1972 Art Show.

Report of Credentials Committee

Dr. H. William Porterfield, Franklin County, Chairman of the Committee on Credentials, re-

ported 162 delegates were seated and eligible to vote.

Election of President-Elect

Dr. Robechek called for nominations for the office of President-Elect. Dr. Thomas Morgan, Gallia County, placed in nomination Dr. Oscar W. Clarke, Gallipolis, Gallia County, Councilor of the Ninth District. The nomination was duly seconded by Dr. John Budd, Cleveland, Delegate, Cuyahoga County. There were no other nominations and **Dr. Clarke was elected by acclamation.** Dr. Clarke then addressed the House of Delegates.

Election of Councilors

Dr. Isador Miller, Delegate, Champaign County, Member, Committee on Nominations, acted as chairman in place of Dr. Joseph Bonta, Franklin County. Dr. Miller presented the report of the Nominating Committee as follows:

First District

As Councilor of the First District to succeed Dr. Paul N. Ivins, Hamilton, the committee placed in nomination Dr. Stephen P. Hogg, Cincinnati. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Hogg was declared elected Councilor of the First District for a term of two years, 1972-74.**

Third District

As Councilor of the Third District to succeed Dr. Dwight L. Becker, Lima, the committee placed in nomination Dr. John C. Smithson, Findlay. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Smithson was elected Councilor of the Third District for a term of two years, 1972-1974.**

Fifth District

As Councilor of the Fifth District to succeed himself, the committee placed in nomination Dr. David Fishman, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Fishman was declared reelected Councilor of the Fifth District for a term of two years, 1972-1974.**

Seventh District

As Councilor of the Seventh District to succeed Dr. Sanford Press, Steubenville, the committee placed in nomination Dr. Robert E. Rinderknecht, Dover. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Rinderknecht was elected Councilor of the Seventh District for a term of two years, 1972-1974.**

Ninth District

As Councilor of the Ninth District to succeed Dr. Oscar W. Clarke, Gallipolis, who was elected President-Elect, the committee placed in nomination the name of Dr. Thomas W. Morgan, Gallipolis. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Morgan was elected Councilor of the Ninth District for a term of two years, 1972-1974.**

Eleventh District

As Councilor of the Eleventh District to succeed himself, the committee placed in nomination Dr. Robert G. Thomas, Elyria. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Thomas was reelected Councilor of the Eleventh District for a term of two years, 1972-1974.**

AMA Delegates

Dr. Miller then presented the nominees for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1973: Drs. Richard L. Meiling, Columbus; Lawrence C. Meredith, Oberlin; Robert N. Smith, Toledo and Robert E. Tschantz, Canton. The nominations being duly seconded and there being no further nominations from the floor, by official action the nominations were closed, and **the nominees presented by the committee were duly elected.**

AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1973, the Nominating Committee placed in nomination the names of Drs. Dwight L. Becker, Lima; David Fishman, Cleveland; Robert P. Johnson, Middletown and H. William Porterfield, Columbus. The nominations being duly seconded and there being no further nominations from the floor, by official action the nominations were closed, and **the nominees presented by the committee were duly elected.**

Committee on President's Address

Dr. Robechek then called for the report of the Reference Committee on President's Address

[see page 691], which was presented by Dr. Richard L. Fulton, Franklin County, chairman of the committee. The report read as follows:

"Dr. Robechek, members of the House, and honored guests. Your Reference Committee on the President's Address met on Monday, May 8, 1972. An audience of physicians was present during part of the deliberations. The rest of the time was spent in Executive Session. Your Committee would like to make the following comments and conclusions regarding Dr. Robechek's Address.

"First of all, contrary to what some members believe, your Committee feels that the Ohio State Medical Association's Council does have the right to act and make decisions between the annual meetings of the House of Delegates. Your Committee further feels that it is the responsibility of the district councilors to represent the feelings of the members of the House of Delegates. This the Council should try to do, and not only does it have the right to act between meetings of the House of Delegates, but under the Constitution, has the responsibility to exercise all the powers and authority conferred on the House of Delegates by the Constitution and the Bylaws.

"Dr. Robechek presented the history of the formation of Medical Advances Institute and enumerated its various functions.

"It was the opinion of the Reference Committee that we have lost sight of the initial purpose for which Medical Advances Institute was founded. Medical Advances Institute was initially formed as a repository for monies and it was contemplated that it would provide educational and meeting expenditures. Such functions have now been relegated to minor importance. Medical Advances Institute has become synonymous with Peer Review and with the modification of PSRO (H.R. 7182). Some of the resolutions presented at this House of Delegates suggest the dissolution of Medical Advances Institute — and Dr. Robechek's statement that these resolutions are 'moot and constitute fiscal irresponsibility' stem from this close association of Medical Advances Institute and Peer Review. Your Committee feels it is this function, not Medical Advances Institute per se, which is being criticized.

"Dr. Robechek stated several times that the Ohio State Medical Association should take a definite stand on issues, and not just settle for negative suggestions. The Council of the Ohio State Medical Association tried to do just that. It gazed into the crystal ball. It felt that National Health Insurance was looming on the horizon and that some type of insurance would become a reality. It was felt that the Bennett Amendment had some objectionable features. In a positive way, this amendment was re-written and submitted by Representative Devine and Representative Betts as H.R. 7182 — the Council's effort to establish a Peer Review mechanism that would be controlled by physicians. Whether the crystal ball gazing comes true or not will be answered in the future.

"The quotations by Wilbur Mills, regarding Dr. Henry and his testimony, reaffirms the Committee's opinion that adequate communication can help educate and shows that physicians can make a positive input into legislative deliberations if the physicians are knowledgeable and will take the time to give of themselves. Conversely, lack of communication frequently fosters misunderstanding and distrust.

"Dr. Robechek apparently feels that PSRO, as envisioned in H.R. 7182, is the most logical of the review mechanisms, but that these mechanisms will not include claims review. He further feels that unless professional standards review is physician-controlled, it should not exist.

"This Committee feels that the present fee review mechanisms that we now have should not be abandoned, but should be increased in scope and more actively utilized.

"Dr. Robechek reminded the Delegates that the actions of the Ohio State Medical Association's Council regarding the development of Medical Advances Institute had been publicized by the following mechanisms:

"1. Officers and councilors visited districts and explained the meaning and purposes of Medical Advances Institute,

"2. Articles regarding Medical Advances Institute were published in the *Ohio State Medical Journal,*

"3. Articles appeared in the *OSMAgram,* and

"4. There was a full day orientation meeting in Columbus regarding Medical Advances Institute. County Society Officers were invited to attend this meeting.

"Our Reference Committee wishes to reassure President Robechek, the House of Delegates and the Council that it feels that all actions of the Council regarding the formation of Medical Advances Institute and the preparation of H.R. 7182 were well-intentioned, appropriate, and for the good of the public and the medical profession.

"The Committee wishes to commend Dr. Robechek for reminding us that there are many organizations (other than physicians' organizations) who feel that they should become the 'one national voice for grass roots medicine.' We of the Ohio State Medical Association are in the thick of battle to preserve the triangle of the

county medical society, the state medical association, and the AMA.

"Several members in our audience commented regarding Dr. Robechek's reference to a 'Foundation of 800 to 900 physicians' now in existence. Although the name of this foundation was not mentioned, its identity was apparent to us. Several members in the audience were critical of Dr. Robechek's statement that 'the foundation has had dealings with a Blue Cross plan — with the ultimate goal of changing the enabling legislation in this State to permit Blue Cross to provide a prepayment plan for physician services.' It was felt that the word 'dealings' implied an underhanded mechanism and a tainted motive. These men did state that they have talked with Blue Cross organizations with the idea of having Blue Cross act as the sales force for their plan later on — much as it does now for Ohio Medical Indemnity. These members further denied knowing of any such legislation and were not aware of any efforts to submit such. These participants did agree with Dr. Robechek that physicians' patients should be indemnified by Blue Shield and not Blue Cross.

"Dr. Robechek expressed his thanks to the Council and to the staff. He further thanked the House of Delegates for the honor accorded him when it elected him President.

"As one of the Past Presidents in the audience stated regarding Dr. Robechek's speech 'He laid it on the line and didn't mince words.' Our Committee agrees.

"Our Committee concludes its report by making three final observations:

"1. Dr. Robechek's speech was written by Dr. Robechek — and no one else,

"2. Sincerity prevailed throughout the entire speech. Dr. Robechek called his shots as he saw them, and was not in the mood to engage in any popularity contest, and

"3. His statements were decisive and to the point and stated with great clarity the direction which the OSMA must take.

"Dr. Emil Meckstroth of our Committee pretty well summarized Dr. Robechek's speech, and our Committee's impression that it was a great speech.

"I quote — 'Blind uncritical loyalty is dangerous in any facet of life.'

"This report respectfully submitted by the members of the Committee on the President's Address: Kenneth W. Clement, M.D., Cuyahoga County; Robert P. Johnson, M.D., Butler County; Emil J. Meckstroth, M.D., Erie County; Richard L. Fulton, M.D., Chairman, Franklin County."

On a motion made and seconded, the House of Delegates, by official action approved the report of the Reference Committee on President's Address.

Report of Resolutions Committee No. 1

Dr. Robert R. Clark, Summit County, reported for Resolutions Committee No. 1 of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 was confronted with 16 resolutions in a unique situation in which 11 of these resolutions dealt with two subjects: PRO-PSRO and MAI. To facilitate discussion and coordinate final decision, these resolutions were amalgamated and the two subjects were considered each as a whole. Two substitute resolutions will be presented consolidating five resolutions in the first and six in the second, encompassing what the Committee considered to be the positive salient points on the two subjects.

"After considerable deliberation, the Committee felt the tenor of the meeting was to take an active, positive approach in these problem areas. Such was felt also to be the mandate of our president in his opening address. The Committee strongly concurred, however, with those who stated that now is the time to relegate the consideration of what the government might demand, of what third parties desired and of what old traditions might dictate to the role of secondary importance. The Committee unanimously decided to present resolutions based on what seems most apparently good for patients, for medicine, and for the delivery of good health care.

"It is with this basis that I present the following resolutions.

RESOLUTIONS 1, 2, 4, 16 and 28-72

Peer Review PSRO; Peer Review PSRO; Local Review by Local Physicians; Peer Review by Component Societies and Reaffirm Autonomy in all Peer Review Activities.

"These resolutions considered by the Committee were submitted by the Delaware County Medical Society, by the Ross County Medical Society, by the Academy of Medicine of Cincinnati, by the Academy of Medicine of Cleveland and the Columbiana County Medical Society, respectively.

"The Committee proposes the following Substitute Resolution in lieu of the above five as introduced:

"The Committee unanimously recommends

the adoption of Substitute Resolution 16-72 and, Mr. President, I so move."

SUBSTITUTE RESOLUTION NO. 16-72
Peer Review

WHEREAS, Peer Review concepts are widely accepted and promoted by the AMA, the Federal Government, and many consumers, and are included in all major health insurance bills now pending before Congress, and

WHEREAS, Facilities, personnel, and the practice of medicine differ in various parts of the State, and

WHEREAS, Certain proposed legislation would provide for methods other than review by local physicians in local communities, THEREFORE, BE IT

RESOLVED, That the establishment of peer norms be the responsibility, primarily, of component medical societies or their medical foundations, either alone or in concert with other contiguous societies, and BE IT FURTHER

RESOLVED, That the administration of Peer Review be similarly left to such organizations, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association establish a Peer Review Organization whose function would be to set up an umbrella of broad general guidelines, to coordinate peer review activities of the component organizations, and to act as arbiter in disputes arising from their administration, and BE IT FURTHER

RESOLVED, That OSMA Peer Review Organization participate in these functions upon request from these organizations or upon failure of these component organizations to perform the function.

By official action, **Substitute Resolution No. 16-72 was adopted.**

RESOLUTIONS 11, 20, 26, 33, 41 and 43-72
Medical Advances Institute

"These resolutions were submitted by the Delaware County Medical Society, by the Mahoning County Medical Society, by Richard E. Hartle, M.D., Delegate, Fairfield County Medical Society, by the Huron County Medical Society, by the Council of the Lake County Medical Society (two resolutions), respectively, and were considered by the Committee.

"The Committee proposes the following substitute resolution in lieu of the above six resolutions as introduced:

SUBSTITUTE RESOLUTION NO. 26-72
Medical Advances Institute

WHEREAS, The Medical Advances Institute was incorporated October 6, 1970 by officers of the Ohio State Medical Association "to promote the social and general welfare, including training, education and research in fields of medicine and personal and public health," and

WHEREAS, The Articles of Incorporation of M.A.I. were amended by the officers of the Ohio State Medical Association to include "development of health care systems," THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association, through M.A.I., continue to promote research in the fields of medicine, and personal and public health care and development of health care systems, including the strengthening of the peer review mechanism at the local level, and BE IT FURTHER

RESOLVED, That the Medical Advances Institute as well as the Ohio State Medical Association refrain from entering into any contractural agreement with any governmental OR OTHER THIRD PARTY agency for implementation of peer review or health care systems without the approval of the House of Delegates in regular or special session.

"The Committee recommends the adoption of Substitute Resolution No. 26-72 and, Mr. President, I so move."

Substitute Resolution No. 26-72 was amended as indicated by the words in capital letters. By official action, **Substitute Resolution No. 26-72 as amended was adopted.**

AMENDED RESOLUTION NO. 56-72
Relative Value Fee Schedule

"Resolution No. 56-72 was submitted by the Allen County Academy of Medicine. It was the opinion of the Committee that the resolution be amended to read:

WHEREAS, The socio-economic facet of medicine is demanding more consideration and has evolved into a definite and primary part of peer review, and

WHEREAS, The past policies of the OSMA have encouraged maintenance of fee levels which, while making medical care available to the senior citizen group without undue hardship, have for some physicians established low "fee profiles" which are accepted as customary by welfare, insurance and medicare, and

WHEREAS, Equitable distribution of medical personnel throughout non-urban areas is related to the potential economic standard which is, has, or can be established in an area, and

WHEREAS, An integral part of "peer review" is the establishment and maintenance of an equitable economic relationship between patient and doctor and between doctor and the medical community in which he practices, and

WHEREAS, No fee schedule guidelines except fee profiles exist which are available to either "peer review" boards or to third party representatives of the patient (welfare, medicare, insurance) to aid in determination of equitable fees, THEREFORE, BE IT

RESOLVED, That the Council of the Ohio State Medical Association be instructed to evaluate the concept of relative value fee schedules.

"Amended Resolution No. 56-72 was recommended for adoption and Mr. President, I so move."

By official action **Amended Resolution No. 56-72 was adopted.**

AMENDED RESOLUTION NO. 18-72
Commending the Council of the Ohio State Medical Association

"The Committee considered Resolution No. 18-72, which was submitted by the Academy of Medicine of Cleveland.

"The Committee recommends that the resolution be amended to read:

WHEREAS, Every major health insurance bill now pending before Congress contains provision for Peer

Review or Professional Standards Review Organizations, and

WHEREAS, None of these plans is entirely physician-directed, and

WHEREAS, Any peer review or professional standards review which is not physician controlled may interfere with the physician's judgment in the practice of medicine causing a deterioration of the quality of medical care, and

WHEREAS, The Ohio State Medical Association helped prepare H. R. 7182, a bill to establish physician directed professional standards review organizations, and

WHEREAS, The 1972 version of the Bennett Amendment has been favorably altered as a result of the introduction of H. R. 7182, THEREFORE BE IT

RESOLVED, That the House of Delegates commend the Council of the Ohio State Medical Association for its foresightedness and astuteness in writing H. R. 7182, and BE IT FURTHER

RESOLVED, That P. John Robechek, M.D., who as president of the Ohio State Medical Association, presided over and guided this work, and James L. Henry, M.D., treasurer of OSMA and president of OSMA's Medical Advances Institute, who testified in favor of H. R. 7182 before the House Ways and Means Committee, be singled out for special commendations for their activities in support of the bill.

"The Committee recommends the adoption of the Amended Resolution No. 18-72 and, Mr. President, I so move."

By official action **Amended Resolution No. 18-72 was adopted.**

RESOLUTION NO. 32-72
H. R. 7182

"The Committee, after considering Resolution No. 32-72, which was submitted by the Huron County Medical Society, recommends that the resolution not be adopted and, Mr. President, I so move."

Text of Resolution as follows:

WHEREAS, If H. R. 7182, or proposed legislation like H. R. 7182 would be enacted, many Private Practicing Physicians believe that it would be the beginning of total nationalized health care or total socialized medicine in America; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association not support H. R. 7182 and actively work to defeat it.

By official action the **House voted to reject Resolution No. 32-72.**

RESOLUTION NO. 36-72
Average Length of Stay

"Resolution No. 36-72, submitted by the Huron County Medical Society, was considered by the Committee.

"The Committee felt it did not have enough information to recommend acceptance or rejection of the resolution. The complexities and ramifications of this matter were considered of magnitude great enough to merit further study AND FOLLOW UP ACTION BY COUNCIL.

"Therefore, the Committee wishes to refer this resolution to the Council of the Ohio State Medical Association for assignment to a proper committee for further study and, Mr. President, I so move."

WHEREAS, Blue Cross of Northwest Ohio is attempting to impose the concept or program of A.I.D.—(Approval by Individual Diagnosis—or, Average Length of Stay) upon the hospitals and the Private Practicing Physicians in its twelve County Region (in Northwest Ohio) and;

WHEREAS, Many Private Practicing Physicians in this same area have voted the Program down since they believe that it would result in the following:

1. Tend to divest the Private Practicing Physician of their medical judgment—inasmuch as Blue Cross proposes to retain the final right to rule on 'medical necessity' of patients' hospitalization length of stay.
2. Attempt to introduce an alien, impersonal, and unethical concept—namely, to coerce Private Practicing Physicians to treat their patients by standards of 'computerized averages' rather than as INDIVIDUALS;

THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reject the A.I.D. (Average Length of Stay) program and advise Blue Cross of Northwest Ohio to desist from further implementing such program and/or revoke same.

By official action Resolution **No. 36-72 was referred to Council of the Ohio State Medical Association.**

RESOLUTION NO. 49-72
H. R. 1

"Resolution No. 49-72, submitted by C. G. Madsen, Jr., M.D., Delegate from Lake County Medical Society, was considered by the Committee. The Committee recommends that the resolution be amended as follows:

AMENDED RESOLUTION NO. 49-72

WHEREAS, Section 223B, of H. R. 1, states that: "may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title," and

WHEREAS, The above obviously involves government in evaluation of clinical services rather than indemnity for the services, and

WHEREAS, The Ohio State Medical Association House of Delegates in Resolution No. 9-71, opposed policies of third party insurers which promise, or create the illusion of promising, that insurers will provide to the patient medical services rather than indemnity against medical costs, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reaffirm its position that insurance carriers and governmental agencies not exercise any authority limiting the nature and extent of clinical services and THAT LIMITATIONS PROPOSED BY INSURANCE CARRIERS AND GOVERNMENTAL AGENCIES BE ENUNCIATED IN FINANCIAL, NOT CLINICAL, TERMS.

"The Committee recommends the adoption of Amended Resolution No. 49-72 and, Mr. President, I so move."

By official action **Amended Resolution No. 49-72 was amended as indicated by the capital letters, and was adopted.**

"I wish to express my personal appreciation to the outstanding members of my Committee for their astute awareness of the many facets with which we were confronted. Their knowledge, dedication, versatility, and plain hard work made the development of the above report possible. It was a real pleasure, personally, to work with them.

"I wish to also express my thanks for the helpful services of the legal counsel of the Association and to the executive staff and the secretarial staff of the Association for their invaluable help.

"This report respectfully submitted by the following members of Resolutions Committee No. 1: John J. Gaughan, Cuyahoga County; William J. Lewis, Montgomery County; Stephen P. Hogg, Hamilton County; John C. Smithson, Hancock County; Harry C. Mack, Lucas County; Robert E. Rinderknecht, Tuscarawas County; Walter B. Devine, Muskingum County; Thomas W. Morgan, Gallia County; John N. Meagher, Franklin County; James T. Stephens, Lorain County; Robert R. Clark, Chairman, Summit County."

By official action **the report of Resolutions Committee No. 1 as a whole, as amended, was approved by the House of Delegates.**

Report of Resolutions Committee No. 2

Dr. William V. Trowbridge, Cuyahoga County, reported for Resolutions Committee No. 2 of which he was chairman. The report read as follows:

"Resolutions Committee No. 2 gave consideration to a total of 22 resolutions. From the open testimony presented during a two-day period, it is clear to your committee that there is certainly no lack of interest in our general membership! We are further impressed by the intellectual stature of delegates chosen by our component county medical societies, as well as by the restraint that they are capable of excercising when involved in the debate of widely divergent opinions. On occasion, diametrically opposite views were debated in public forum. On no occasion, however, was there any unseemly acrimony, and the contentions were presented in gentlemanly fashion, on a level we considered to reflect great credit upon the Ohio State Medical Association, and on the medical profession as a whole.

"Unless we happen to be faced with a large silent majority, the consensus was eminently clear in respect to all of the resolutions we considered. Although there were times when your Resolutions Committee was not unanimous in its views, there was no instance wherein a dissenting response was of sufficient magnitude to induce the presentation of a minority report. Accordingly, Mr. President, our report to you, and to this House of Delegates, represents a clear majority response from the committee on all of the resolutions considered by us. In this respect, there were occasions when members of your committee demonstrated great restraint in subordinating strong personal opinions that were clearly contrary to the majority opinions of the committee and often contrary to the majority of those delegates testifying before your committee. In spite of this, I want to make it eminently clear that on no occasion was there a capitulation of a committee member, or the committee as a whole, to what seemed to be simply convenient and politic. We attempted—and your chairman fervently believes we succeeded—to condense what the physicians in the Ohio State Medical Association considered to be the right and proper response to those issues presented for our consideration.

"Many resolutions were related to the same topic or problem. In those cases, we attempted to discuss them in groups, and an attempt was made, where possible, to consolidate the response of your committee into a succinct resolution. Accordingly, this report will not present all of the resolutions in the numerical sequence as they were initially listed.

RESOLUTION NO. 12-72
Funding of Comprehensive Health Plans

"This resolution was submitted by the Academy of Medicine of Cleveland. It was represented before the Committee by Dr. William F. Boukalik, a Delegate from the Fifth District, and Dr. Boukalik convincingly urged the adoption of this resolution. Further, he presented what was viewed by the majority to be adequate reason for that recommendation. We feel that it should be noted that there was no testimony presented to your committee in opposition to this resolution."

RESOLUTION NO. 12-72

WHEREAS, Financing of area-wide Comprehensive Health Planning Agencies under PL 89-749 is accomplished by contributions for 50 per cent of the total budget from major providers, community business and other organizations, and local government bodies and 50 per cent matching funds from the Federal Government, and

WHEREAS, It has become an increasingly difficult task to raise voluntary local funds on a continuing basis, THEREFORE, BE IT

RESOLVED, That OSMA initiate and endorse enabling state and federal legislation to allow partial funding

by the State and thus reduce the burden placed upon local communities in support of this and similar programs.

"It is the consensus of your committee that this resolution, as submitted, be adopted, and Mr. President, I so move."

By official action, **Resolution No. 12-72 was adopted.**

RESOLUTION NO. 13-72
Medicare Part B

"We next considered Resolution No. 13-72, a vigorous protest to the arbitrary reduction of benefits to Medicare recipients by Nationwide Mutual Insurance Company. This resolution was also submitted by the Academy of Medicine of Cleveland."

RESOLUTION NO. 13-72

WHEREAS, The Commissioner of Social Security in 1966 promised beneficiaries that medical insurance payments under Medicare Part B "will be based on the customary charges of your doctor and the prevailing (usual) rates charged for similar medical services in your area," and
[Health Insurance Under Social Security, U.S. Department of Health, Education, and Welfare; Social Security Administration; June, 1966; p. 15]

WHEREAS, Nationwide Mutual Insurance Company, carrier for Medicare Part B in Ohio, has been progressively reducing the amount it will reimburse for medical services, and

WHEREAS, This policy has caused hardship to many elderly patients who believed they were were more adequately indemnified under Medicare Part B; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association inform all Congressmen and Senators representing the State of Ohio in the Congress of the United States of the hardship to elderly citizens being wrought by the inadequacy and progressive reduction of reimbursements allowable under Medicare Part B, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association urge all member physicians to inform all their patients, in writing, of this arbitrary reduction in Social Security benefits for which all citizens are payng or have paid, and urge them to protest this reduction, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association urge member physicians to refuse to accept assignment under Medicare Part B, while assuring the elderly that each physician will continue to care for his elderly patients regardless of Medicare coverage, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association vigorously protest reduction of benefits under Medicare Part B to both the carrier and the Social Security Administration and seek to have adequate benefits, based upon usual and customary charges, restored to Medicare beneficiaries.

"Again, it was the consensus of your committee that this resolution, as submitted, be adopted, and, Mr. President, I so move."

By official action, **Resolution No. 13-72 was adopted.**

RESOLUTION NO. 17-72
Closed Panel or Prepaid Group Practice

"This resolution is submitted by the Academy of Medicine of Cleveland. Since it is quite similar in intent to Resolution No. 48-72, submitted by the Academy of Medicine of Toledo and Lucas County, the two resolutions were considered in conjunction. This deliberation led to our consolidation of the two into a Substitute Resolution, which we feel reflects the full intent of both, as follows:

SUBSTITUTE RESOLUTION NO. 17-72

WHEREAS, The public is exhibiting a growing interest in improvement in the present system of health care delivery, seeking reduced costs, high quality, and greater accessibility, and

WHEREAS, Alternative health care systems have been developed, and others are evolving, which are alleged to be able to provide quality care more efficiently, and

WHEREAS, Involvement in these alternative health care delivery systems can provide for an objective evaluation of their effectiveness and their quality, and

WHEREAS, The adoption of Substitute Resolution No. 14-71 by the 1971 House of Delegates of the Ohio State Medical Association has appeared to prohibit physicians and Ohio Medical Indemnity, Inc., from becoming involved in certain alternative health care delivery systems; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association not oppose the involvement of reputable physicians or the Ohio Medical Indemnity, Inc., in closed panel or prepaid, group practice organizations, or any other health care delivery systems provided that the principles of high quality medical care and physician control of the practice of medicine be maintained, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association encourage a fair comparison of performance of various health eare delivery systems, and that it communicate the results of such studies to the public as a basis for free choice among alternative systems.

"Mr. President and fellow Delegates, the heated debate over this resolution created enough light to provide a clear consensus that our Association must adjust to the realities of our time, and recognize the existence of philosophies of medical care delivery that we could not accept in other days. We are, by no means, frivolous in our reconstructed stance, nor are we apologetic for what we recognize to be a recommendation for very major policy change in the OSMA. We can only hope that this House of Delegates will agree with us in the conviction that our organization **must** be sensibly flexible, and adaptable to a changing world.

"It is the consensus of your Committee that this Substitute Resolution be adopted, and, Mr. President, I so move."

By official action **Substitute Resolution No. 17-72 was adopted.**

RESOLUTION NO. 21-72
Review of OMI, Inc., Coverages

"Prior to the outset of our deliberations, the Defiance County Medical Society submitted suggested changes in this Resolution. These significantly altered the initial proposal, and the suggested changes have been incorporated, with other changes by the Committee into:

SUBSTITUTE RESOLUTION NO. 21-72

WHEREAS, The present Blue Shield-Ohio Medical Indemnity plans now carried by many subscribers in some areas of the State of Ohio, provide inadequate coverage, and

WHEREAS, The patient, who has the majority of his hospital bill paid by Blue Cross and only a limited amount of his doctor's bill paid by Blue Shield, assumes that doctors must be charging too much, and,

WHEREAS, The Blue Shield-Ohio Medical Indemnity, Inc., is generally recognized as being controlled by the Ohio State Medical Association and/or members thereof, THEREFORE BE IT

RESOLVED, That the House of Delegates direct the Council of the Ohio State Medical Association to encourage Ohio Medical Indemnity to exert maximum effort throughout the State of Ohio to make available to, and encourage, individual and group (including employees and their representatives, as well as employers) policyholders to upgrade low indemnity policies to the UCR contracts, and, BE IT FURTHER

RESOLVED, That all Ohio physicians assist, within proper limits, in encouraging these improvements.

"Your Committee is unanimous in recommending the adoption of this Substitute Resolution, and, Mr. President, I so move."

By official action **Substitute Resolution No. 21-72 was adopted.**

RESOLUTION NO. 23-72
Invoice for Health Care Under Medical Assistance Program

"This Resolution is duplicated in large part by Resolution No. 27-72. The two were considered jointly, and the results of our deliberations have been set forth in a Substitute Resolution.

"We note that there was no one to appear before the Committee in opposition to either of these Resolutions. In spite of the complaints set forth, your Committee recognizes the fact that physicians now accept the necessity for use of "standard forms" to permit the practical operation of various agencies, both private and governmental. We are accustomed to, and accept, the "Standard Forms" of Medicare, OMI, Medical Mutual, CHAMPUS, The Ohio Bureau of Workmen's Compensation, as well as many others—though we confess our belief that none of these is perfect! It is clear to us that the Ohio Department of Welfare cannot be expected to be an exception to this established pattern of billing, and be restricted from the use of a "Standard Form." Our careful scrutiny of Form DPW 2157 (7-70) does not convince us that this is truly a "bad form," or one that imposes an undue hardship upon the physician, if the physician is relieved of the burden of coding, as presently required by the Ohio Department of Welfare. We view it as totally unreasonable, and unacceptable, for the Ohio Department of Welfare to expect physicians to provide this coding function for them, since it is clearly a proper function of their agency. In view of these views, your Committee presents:

SUBSTITUTE RESOLUTION NO. 23-72
Ohio Welfare Department Forms

WHEREAS, The OSMA recognizes the need for a standard billing form for professional services rendered to recipients of benefits from the Ohio Department of Welfare, and

WHEREAS, All physician members of the OSMA wish for their welfare patients to be other than "second class citizens" in having their bills for medical services paid promptly, and

WHEREAS, The OSMA refuses to permit the Ohio Department of Welfare to transfer its administrative responsibilities for coding to the treating physician, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association inform the Ohio Department of Welfare that:

1.) Ohio physicians will not accept the coding responsibilities that have been imposed upon them, in the present forms for billing.

2.) Members of the OSMA will cooperate by completing an Amended Form DPW 2157, when such an amended form is submitted to, and approved by, the Council of the OSMA.

"Your Committee is unanimous in recommending the adoption of this Substitute Resolution, and, Mr. President, I so move."

By official action **Substitute Resolution No. 23-72 was adopted.**

RESOLUTION NO. 24-72
Exposure of Failure of Government Medical Programs

"This Resolution is presented by the Richland County Medical Society. Your Committee feels that this is a superb Resolution, and we commend the authors of it. We did exercise our prerogative by making very minor changes in the wording, but these are not substantive changes.

AMENDED RESOLUTION NO. 24-72

WHEREAS, Many of the physicians of Ohio feel that there is a marked credibility gap between what Social Security, Medicare and Medicaid have promised and have actually delivered, and

WHEREAS, Physicians are often mistakenly blamed for the failures of the existing government programs, and

WHEREAS, The exorbitant cost of the aforementioned government programs is mistakenly ascribed to excessively high physician's fees, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association bring to the attention of the citizens of the State of Ohio that the Medicare and Medicaid programs have been misrepresented, inadequate, and inefficient, and that an exposure of these deficiencies be made at the earliest possible convenience of the Ohio State Medical

Association, by the most effective news media, and BE IT FURTHER

RESOLVED, That this action be brought promptly to the attention of the American Medical Association.

"Your Committee is unanimous in recommending that Amended Resolution No. 24-72 be adopted, and, Mr. President, I so move."

By official action **Amended Resolution No. 24-72 was adopted.**

RESOLUTION NO. 29-72
Medicare and Medicaid

"Mr. President, your Committee gave more than passing attention to this Resolution. We noted that there was not a single person appearing before the Committee to present it, defend it, or endorse it in any way. Despite this, we did not ignore the sentiments embodied in the Resolution. In fact, many of us share the disenchantment with the Medicare and Medicaid programs, as they are expressed, but we cannot view the total thrust of the Resolution other than being completely unrealistic.

"If nothing else, this Committee is convinced that the OSMA will not distinguish itself by 'tilting at windmills.'

RESOLUTION NO. 29-72
Medicare and Medicaid
(By the Huron County Medical Society)

WHEREAS, Medicare and Medicaid (PL89-97) during the years of their existence, have increasingly proven to be unsound, destructive of patient-doctor relationship, detrimental to medical progress, and financially disastrous; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association petition the Congress of the United States to recognize these inherent defects and refrain from expanding this disastrous system in any way, and consider seriously the possibility of eliminating same.

"We are unanimous in our recommendation that this Resolution be not adopted, and, Mr. President, I so move."

By official action **the House voted to reject Resolution No. 29-72.**

RESOLUTION NO. 34-72
Health Care—A Negotiable Service

"This Resolution was presented by the Delegate from Huron County, and he was eloquent and convincing in his presentation. Your Committee made several changes in this Resolution, in the hope of strengthening its intent, and these changes were made after seeking advice from legal counsel to the OSMA, James E. Pohlman, Esq.

"We submit the following:

SUBSTITUTE RESOLUTION NO. 34-72

WHEREAS, There has been a continuing and recurring representation, by politicians and social schemers, that there is a "right" to medical care, and

WHEREAS, In fact, this is an erroneous representation, misleading the public regarding its true right to the availability of medical care, and

WHEREAS, The private medical practitioner has a reasonable, moral and constitutional right to dispose of his services pursuant to a mutually agreeable contract, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association go on record in stating that medical care and medical services are reasonably negotiable by a mutually satisfactory contract between the physician and the patient, under the concept of individual responsibility and liberty to contract. In so doing, there will prevail mutual respect, maintenance of dignity and honor of both parties, and a preservation of constitutionally guaranteed freedoms for all.

"Your Committee unanimously recommends the adoption of this Substitute Resolution, and, Mr. President, I so move."

By official action **Substitute Resolution No. 34-72 was adopted.**

RESOLUTION NO. 35-72
Liberty To Contract

"This Resolution was also presented by the Delegate from Huron County. The presentation, again, was eloquent and convincing, and your Committee is in full accord with the intent of the Resolution. Legal Counsel to the OSMA, James E. Pohlman, Esq., stated his belief that any legal action initiated at a State level would not prove fruitful. This, coupled with information presented to the Committee by our AMA Representatives, regarding similar steps presently under way by the American Medical Association, at a National level, led us to the conviction that this resolution could serve no fruitful purpose.

"Accordingly, your Committee recommends that this Resolution be not adopted, and Mr. President, I so move."

RESOLUTION NO. 35-72

WHEREAS, Volume XVI of Corpus Juris Secumdum, on page 1067 of the Constitutional Law, Article 210 states—
"The liberty to contract, as guaranteed by the various Constitutions, includes the right of parties to incorporate into their contracts, otherwise valid, such terms as may be mutually satisfactory to them, the right to mortgage property, the right to fix a price for personal services, and the right to decline to enter into a contract." THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association request Legal Counsel of OSMA and Legal Counsel of the American Medical Association to request proper legal authorities, including the United States Supreme Court, if necessary, to rule on the possible Constitutional violation, by the Federal Price Commission, of Articles IX, and X of the Amendments to the United States Constitution with reference to the individual's right to 'Liberty To Contract.'

By official action **the House voted to reject Resolution No. 35-72.**

RESOLUTION NO. 40-72
Phase II

"Resolution No. 40-72 is presented by the Lake County Medical Society. Dr. Carl Madsen,

appeared before your Committee, in support of the Resolution.

"Your Committee could not quarrel with any part of this resolution. We did make an extremely minor change in the wording, as reflected in that portion underlined. This does not produce any substantive change.

AMENDED RESOLUTION NO. 40-72

WHEREAS, A twenty-two member special committee has been appointed by the President of the United States especially to consider the cost of medical care, and

WHEREAS, Thereby, physicians have been singled out and made to bear the implication that they contribute peculiarly to the national inflation, and

WHEREAS, Advisory committees tend to become regulatory boards, and

WHEREAS, No physician directly responsible for his patients' care on a fee-for-service basis is among those currently appointed to this special committee, THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association House of Delegates call to the attention of the President of the United States this regrettable omission, and BE IT FURTHER

RESOLVED, That the American Medical Association be instructed to prepare a limited list of qualified practitioners to be submitted to the President of the United States, and BE IT FURTHER

RESOLVED, That the American Medical Association, through its Committee on Private Practice, strongly urge the selection of appointees thus qualified in its communication of desire to the President of the United States.

"Your Committee is unanimous in recommending that this Amended Resolution be adopted, and, Mr. President, I so move."

By official action **Amended Resolution No. 40-72 was adopted.**

RESOLUTION NO. 42-72
H.M.O.'S

"Resolution No. 42-72, submitted by the Lake County Medical Society, was submitted to careful scrutiny by your Committee. Much testimony was heard, and considered, both favorable and unfavorable to the Resolution.

"After careful deliberation, the Committee feels required to present our VIEW that we do not believe the medical profession presently has enough information to either blanketly endorse or condemn, out-of-hand, any capitation system of medical care delivery.

"It is the unanimous recommendation of your committee that this Resolution, as presented, be NOT adopted, and, Mr. President, I so move."

RESOLUTION NO. 42-72

WHEREAS, We believe that physician employees of a Health Maintenance Organization must owe their first allegiance to their corporate employer and cannot give the patient anything better than a secondary or divided loyalty, and

WHEREAS, Prescription of medical procedure for the purpose of financial profit is contrary to ethical medical practice, and

WHEREAS, Such an act is contrary whether the resultant profit goes to laymen or to members of the medical profession, individually or corporately, and

WHEREAS, Omitting prescription of medical procedure similarly for the purpose of profit would be likely to be viewed similarly as contrary to ethical medical practice, and

WHEREAS, Concealment from the patient's view of such an omission might follow in the course of there being threatened loss of profit to corporate partners, and

WHEREAS, The legal doctrine of informed consent might come to embrace full disclosure to the patient of alternative or optional medical procedures anywhere available, not just locally, and

WHEREAS, It is not in the patient's best interest to burden him with the task of dragging out a reluctant physicians information about alternatives when physicians alone harbor that knowledge and may lose financially by its being revealed, THEREFORE BE IT

RESOLVED, That encouragement by the Regional Medical Programs of the development of "Health Maintenance Organizations" be protested as encouring the cultivation of an administrative environment tending toward omissions of prescription and information to the patient.

By official action **the House voted to reject Resolution No. 42-72.**

RESOLUTION NO. 44-72
Regional Medical Programs

"This Resolution is presented by the Lake County Medical Society. Forceful testimony was presented by Dr. Carl Madsen, the author of the Resolution. Your Committee agrees, in every respect, with this Resolution. We are solidly in favor of the educational concepts embodied in the original legislation, but we are unanimous in our opposition to the expansion of these programs into Other Areas.

RESOLUTION NO. 44-72

WHEREAS, Regional Medical Programs legislation deals with education of medical personnel and not primarily with direct delivery of patient care, the earlier concept of medical care center complexes having fallen from congressional favor, and

WHEREAS, Regionalization of education is one thing and regionalization of medical care is another, and

WHEREAS, Regionalization of medical care is again being proposed this time through the Federal Register, Vol. 37, #13, January 20, 1972, proposing alteration of the Regional Medical Programs "mission" to give special emphasis... to encourage the development of regional cooperative arrangements..."which show promise of leading to the regionalization of health resources," THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reiterate its opposition to governmental formalization of medical care regionalization, as expressed afresh in the issue of the Federal Register cited, and BE IT FURTHER

RESOLVED, To have a similar resolution put before the House of Delegates of the American Medical Association.

"Your Committee unanimously recommends

that this Resolution be adopted, and, Mr. President, I so move."

By official action **Resolution No. 44-72 was adopted.**

RESOLUTION NO. 45-72
Capitation (and Ethics)

"This Resolution, presented by the Lake County Medical Society, received lengthy attention and deliberation. There is not a single member of this Committee who can endorse the capitation system as an ideal form of medical care delivery! None-the-less, it is the consensus of your Committee that participation of a physician in a capitation system of medical care delivery does not, in and of itself, constitute UNETHICAL conduct. Accordingly, we recommend that this Resolution be NOT adopted, and, Mr. President, I so move."

RESOLUTION NO. 45-72

WHEREAS, Practicing physicians have been admonished that it is unethical to permit parties outside the physician-patient relationship to dictate or to interfere with the conditions under which the physician will render medical service, and

WHEREAS, In recent years particular importance has been attached to preventing especially those parties offering the patient financial assistance from interfering and

WHEREAS, It has been possible to identify interference when those parties providing financial assistance to the patient have been distinctly identified as separate from the physician, and

WHEREAS, Fusion of the physician and the party providing financial assistance would render those same efforts at interference less easily identified, and

WHEREAS, The capitation form of financing Health Maintenance Organizations effectively fuses the physician and the party providing financial assistance, and

WHEREAS, A recent court case has led Bernard D. Hirsch, General Counsel for the American Medical Association, to remark that, "if a physician were to be held responsible for patients' bills, it would probably affect the quality of care," and

WHEREAS, Capitation financing makes the physician responsible for patients' bills, THEREFORE, BE IT

RESOLVED, That acceptance by physicians of the capitation form of financing medical services be declared acceptance of a form of financing tending to interfere with the physician's rendering medical service and, so, an unethical practice.

By official action the **House voted to reject Resolution No. 45-72.**

RESOLUTION NO. 59-72
Health Maintenance Organizations

"This Resolution was submitted by the Summit County Medical Society, and was considered jointly with the deliberations on Resolutions No. 17-72 and No. 48-72. In view of our recommendations embodied in Substitute Resolution No. 17-72, we see no further need for this Resolution. Accordingly, it is the consensus of your Committee that this Resolution be NOT adopted, and, Mr. President, I so move."

RESOLUTION NO. 59-72

WHEREAS, The Nixon administration's goal is that 90 per cent of the population have the available option of receiving physicians' care through a health maintenance organization by 1980, and

WHEREAS, Four component medical societies of the AMA and over forty other medical groups have been awarded planning and development grants for health maintenance organizations already in 1972, BE IT THEREFORE

RESOLVED, That a reference committee of the House of Delegates have an open discussion of health maintenance organizations including formal presentations by staff and officers of facts on this matter, the committee making comment to the House on this general subject, and BE IT FURTHER

RESOLVED, That the Council of OSMA continue research of the subject of county medical societies applying for HMO planning grants with the following out-of-state organizations, rendering a report and comment to all constituent county medical societies at the earliest possible date: Fulton County Medical Society, Atlanta, Georgia; Maricopa County Medical Society, Phoenix, Arizona; the Medical Society of Delaware; Mesa County Medical Society, Grand Junction, Colorado; John Hale Medical Society (NMA), San Francisco, California.

By official action **the House voted to reject Resolution No. 59-72.**

RESOLUTION NO. 61-72
Revocation of OMI Utilization Review Program

"This Resolution was presented by the Stark County Medical Society, and evoked lengthy discussion and debate. It is the consensus of your Committee that this Resolution is, in many respects, unrealistic. We do not believe that OMI has, in truth, made any attempt to 'evade the Ohio State Medical Association Peer Review Program.' In fact, it is well known that OMI has, on occasion, requested the benefits of that Peer Review mechanism. Your Committee is of the belief that the authors of this Resolution are confusing utilization review with peer review.

"We cannot envision any way in which any insurance program could function and survive without some form of utilization review. Any total elimination of utilization review in OMI would eventually destroy this corporation, owned by the OSMA.

"The executives of OMI have defended their questionnaire, but, on our demands, have promised to withdraw it completely.

"In view of the above stated opinions and facts, it is the consensus of this Committee that Resolution No. 61-72 be NOT adopted, and, Mr. President, I so move."

RESOLUTION NO. 61-72

WHEREAS, Ohio Medical Indemnity, Inc., is a Medical Indemnity Prepayment Corporation not for profit and wholly owned by the members of the Ohio State Medical Association, and

WHEREAS, Ohio Medical Indemnity has attempted to evade the Ohio State Medical Association Peer Review

Program by adopting a Utilization Review Program conceived by the same National Association of Blue Shield Plans that has publicly and nationally opposed county medical society review, and

WHEREAS, Ohio Medical Indemnity states that its Utilization Review Plan will be used to set up parameters of care "based on actual practice of medicine, in contrast to the ideal practice of medicine as would be the case if a segment of the profession drew up what they feel these parameters should be," and

WHEREAS, This same plan intends to question the veracity and honesty of physicians by sending patients post-payment audit questionnaires at random, and

WHEREAS, The existing review system established by the Ohio State Medical Association in cooperation with the county medical societies has enjoyed remarkable and exemplary success, as witnessed by the Bureau of Workmen's Compensation report showing that only 201 out of approximately one million claims in six years needed to be referred to the Ohio State Medical Association for review (as of February 11, 1972), THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association hereby finds the Ohio Medical Indemnity Utilization Review Plan to be repugnant and unacceptable in the best interests of the patient and quality medical care, and BE IT FURTHER

RESOLVED, That this House of Delegates instructs The Council of the Ohio State Medical Association to take immediate steps to induce Ohio Medical Indemnity to abandon and discard its intended Utilization Review Program, and BE IT FURTHER

RESOLVED, If Ohio Medical Indemnity declines to discard and discontinue this program, the Council is instructed to take immediately any and all steps necessary to achieve this mandate from this House of Delegates.

By official action **the House voted to reject Resolution No. 61-72.**

RESOLUTION NO. 62-72
OMI "Hold Harmless"

"This Resolution, submitted by the Stark County Delegation, was considered, at great length, in conjunction with Resolution No. 63-72, submitted by the Delegation from Huron County, since they both are directed to the same subject.

"Lengthy discussion and debate was held, both in open forum and in Executive Session of the Committee.

"Your Committee rapidly came to a unanimous meeting of minds to the effect that the catch phrase 'Hold Harmless' is, indeed, repugnant to Ohio Physicians. Further, we unanimously hold this phrase, 'Hold Harmless,' to be maldescriptive and, in all ways, unacceptable to the OSMA membership!

"In spite of this unswerving stand in rejecting the 'Hold Harmless' phrase, your Committee did, in the clear majority, accept several premises as being realistic. First, we recognize that a support of Fair Fees, and the Peer Review System is nothing more than a continuation of principles long espoused by organized medicine, including the OSMA. Moreover, we recognize that a support of Fair Fees has been well-tested, in that millions of claims generated by the 25-million-odd Blue Shield subscribers, covered by similar programs in the United States, have presented so few problems as to be virtually immeasurable. We face, as well, the fact that a Support of Fair Fees will benefit both the physician and the patient. Lastly, one cannot escape the fact that OMI must be able to provide some assurance that fees will be fair, under the UCR principle, in order to compete in the market place.

"Testimony was heard to the effect, and your Committee recognizes that what is good for an insurance company is not always good for the medical profession. One day, this Association may have to grapple with, and resolve, the question of this conflict. At present, your Committee believes that any such conflict does not begin to negate the clear advantages to be derived by a continuing, strong association of OMI and the OSMA.

"With the stated misgivings in mind, your committee eventually arrived at a firm consensus in the following:

SUBSTITUTE RESOLUTION NO. 62-72

WHEREAS, The OSMA has consistently espoused the concept of fair fees for medical services, and the Peer Review mechanisms, and

WHEREAS, The Ohio State Medical Association owns the majority shares of Ohio Medical Indemnity, and must also support these principles, and

WHEREAS, The loss of contracts presently held by OMI, or potentially available to them in the future, would be a tragic loss, since those contracts would necessarily gravitate to commercial carriers who neither request our advice and opinions nor give heed when we gratuitously present our advice or opinions, and

WHEREAS, We wish to continue our communication with Ohio Medical Indemnity, Inc., THEREFORE BE IT

RESOLVED, That this House of Delegates go on record, recommending to OMI the deletion of the phrase "Hold Harmless" from all future contracts and negotiations, as well as from all presently existing contracts, as rapidly as feasible, and, FURTHER BE IT

RESOLVED, That this House of Delegates go on record as continuing its support of OMI, as well as the principle of Fair Fee Support, and, BE IT FURTHER

RESOLVED, That the OSMA recognizes and approves of, the necessity of OMI to continue to amend its contracts, periodically, in order that they may continue to be competitive in the market place — although we Insist that these contracts be worded in such a fashion to remain consistent with the policies of OSMA and this House of Delegates.

"It is the consensus of your committee that

this Substitute Resolution be adopted, and, Mr. President, I so move.

By official action **Substitute Resolution No. 62-72 was adopted.**

RESOLUTION NO. 64-72
Withdrawal of OMI from National Association of Blue Shield Plans

"This Resolution, also presented by the Stark County Medical Society again evoked lengthy discussion. Your Committee is unanimous in expressing our **extreme** displeasure with the press releases of the National Association of Blue Shield Plans that were so quickly and completely distorted. We can only hope that NABSP, as a result of this fiasco, will be less naive in their future dealings with the news media. Still, we recognize that NABSP holds no corner on "bloopers" of this magnitude. There are those among us with vivid memories of similar distortions, by the news media, attributed to our own Society and to our own officers! An isolated unfortunate incident such as this, despite its magnitude, would hardly justify a withdrawal of OMI from the NABSP. Since the latter organization disclaims any complicity in the view, or the publication of the statement, that "If the Medical Societies get into this processing business, they will pay the doctors whatever they want," we hardly feel it fair to hold the NABSP accountable for this unfortunate statement that has been given such wide currency.

"The broad advantages of remaining a member of the NABSP have been delineated, including the huge benefits in the marketing of National accounts, and the reciprocity in processing claims for services rendered to patients holding contracts in the Blue Shield Plans of other states. We are of the view that these clear advantages far outweigh any nebulous advantages that might accrue to OMI through withdrawal from the National Association of Blue Shield Plans.

"It is the consensus of your Committee that this Resolution be NOT adopted, and, Mr. President, I so move."

RESOLUTION NO. 64-72

WHEREAS, The National Association of Blue Shield Plans, while engaging in Congressional lobbying activities, caused to be published nationwide newspaper articles claiming America's physicians overcharged their patients 500 million dollars in 1971, and

WHEREAS, This same Association testified in favor of a Professional Standards Review Plan (H. R. 1) that is the antithesis of professional review envisioned by the medical profession, and

WHEREAS, Spokesmen for the NABSP have stated in regard to Professional Review by Medical Societies, "we are strongly opposed to this (medical society review). If the medical societies get into this processing business, they will pay the doctors whatever they want," THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association hereby directs the Council of the Ohio State Medical Association, which casts the entire vote of the stockholders of Ohio Medical Indemnity, Inc., said stockholders being the physicians of the OSMA, to direct Ohio Medical Indemnity, Inc., to withdraw immediately from any membership in or agreements with the National Association of Blue Shield Plans, and BE IT FURTHER

RESOLVED, That, if the Board of Directors of Ohio Medical Indemnity, Inc. fails to carry out these steps, the Council of the Ohio State Medical Association is hereby instructed to execute immediately all steps necessary to achieve the removal of Ohio Medical Indemnity, Inc., from any membership in or agreement with the National Association of Blue Shield Plans.

By official action **the House voted to reject Resolution No. 64-72.**

REPORT OF AD HOC COMMITTEE ON HEALTH CARE DELIVERY

"Lengthy hearing was given to this report, with able testimony received from several of the authors. Many testified to their doubts that any Foundation will diminish the cost, control the quality, or bring about a better distribution, of medical care. Many on your Committee share this lack of enthusiasm for the Foundation principle, and for the fond hopes of those who view the Foundation approach to be some form of panacea. We cannot blind ourselves, however, to the fact that Foundations have already been started in the State of Ohio, and that new ones will follow. Taking this fact as a point of departure, we would want the OSMA to establish guidelines and policies, with the requirement that any of our member physicians participating in such Foundations conform to those guidelines and policies. It is our belief that such action will provide an acceptable alternative to plans, that will most certainly be advanced by others, in which there is no provision for any control that might be exercised by the OSMA.

"We wish to commend the Ad Hoc Committee for their extensive labors in this two-year task, and we particularly commend them for the fruit of their labor.

"Mr. President, since you have referred this report to our Committee as a Resolution, we submit the following Resolution, in order that the House of Delegates may give deliberation to this report, and act upon it:

RESOLUTION NO. 66-72
Model Medical Care Foundation

WHEREAS, The Ad Hoc Committee for the Study of Health Care Delivery Systems has submitted a report of their Study, under date of May 8, 1972, and

WHEREAS, We find ourselves in agreement with the substance of that report, as well as the recommendations set forth therein, THEREFORE BE IT

RESOLVED, That the House of Delegates instruct this committee to formulate the specifics of a Model Medical Care Foundation that will embody the con-

cept of regional operational foundations, with their local peer review of quality and cost, and with the intent that this Model State Foundation is to serve as a coordinating body, an umbrella of general policy, and the primary negotiating body for Foundation Programs within the State of Ohio, and BE IT FURTHER

RESOLVED, That appropriate financing and disbursement methods be recommended, and BE IT FURTHER

RESOLVED, That the policies of this Model Foundation Program be consistent with existing policies of the OSMA and the House of Delegates, and BE IT FURTHER

RESOLVED, That this Model Foundation Program be presented to the House of Delegates at the earliest time, for final action.

"It is the consensus of your Committee that this Resolution be adopted, and, Mr. President, I so move."

By official action **Resolution No. 66-72 was adopted.**

"Mr. President, and Fellow Delegates:

"Resolutions Committee No. 2 has labored most diligently, and through late hours, in an effort to give a head-on, honest confrontation to the thorny issues presented to us. We have no doubt that we have angered many of our colleagues, but our conclusions have been based on what we fervently feel was the best solution for our patients, who must always come first. We offer no apology for relegating the interests of the physician to what might appear to be second place, being firm in our belief that what is best for the patient is always best for the physician. You are all deeply indebted to the members of this committee for their devoted labors in your behalf. They are: Roland A. Gandy, Jr., Lucas County; Foster J. Boyd, Clinton County; Jerry L. Hammon, Miami County; Paul E. Lyon, Marion County; C. Edward Pichette, Mahoning County; Paul Mastros, Jefferson County; Gregory B. Krivchenia, Washington County; Harry Nenni, Lawrence County; Joseph A. Bonta, Franklin County; A. Burney Huff, Wayne County; William V. Trowbridge, Chairman, Cuyahoga County.

"On behalf of the Committee, I wish to thank the legal counsel to OSMA, Mr. James E. Pohlman, for his assistance and knowledgeable advice. We are also indebted to the capable staff of the Ohio State Medical Association. I must especially thank Mrs. Carol Maddy for her superb help, for her pleasant and happy response to the adversity imposed upon her by having to work for me. Likewise, I cannot adequately thank Chuck Edgar, and other staff members for the huge assistance that they so expertly provided. Without them, our task could not have been completed.

"Mr. President, I move that the Report of Resolutions Committee No. 2, as a whole unamended be adopted.

By official action **the House voted to adopt the report as a whole, as presented.**

Report of Resolutions Committee No. 3

Dr. Jasper M. Hedges, Pickaway County, reported for Resolutions Committee No. 3 of which he was chairman. The report read as follows:

"Mr. President and Members of the House of Delegates.

"Resolutions Committee No. 3 held hearings on 17 resolutions, plus one emergency resolution introduced on the floor of the House by consent of two-thirds of the delegates present at the first session of the House of Delegates, and a report from the Commission on Medical Education.

"The committee gave thoughtful consideration to all testimony before it. The committee's open session lasted approximately six hours and the executive session consumed an additional five hours. The committee felt that adequate consideration was given to all of those members of the House of Delegates and the Ohio State Medical Association who appeared before it.

RESOLUTION NO. 3-72
Notice to County Medical Societies Re Legislative Action

"The first resolution considered by this committee was Resolution No. 3-72, submitted by the Academy of Medicine of Cincinnati. It was the unanimous opinion of the committee that the thought behind the resolution was good, but the implementation of the resolution could not ever be practical.

"The committee unanimously recommends that Resolution No. 3-72 not be adopted and, Mr. President, I so move."

RESOLUTION NO. 3-72

WHEREAS, The Ohio State Medical Association Legislative Committee and Council develop Legislative Bills for both the Ohio Assembly and Congress; and

WHEREAS, The Legislative Bills introduced express certain medical policies, which affect the medical profession; and

WHEREAS, Physician members may disagree with the intent, spirit and wording of such legislative proposals; THEREFORE, BE IT

RESOLVED, That prior to presenting such Legislative Bills bearing an Ohio State Medical Association endorsement that such Legislative Bills be circulated and directed to the attention of the Officers of the County Medical Societies, before they are dropped in

the Legislative hopper, either in the Ohio General Assembly or in the United States Congress.

By official action the House voted to reject Resolution No. 3-72.

RESOLUTION NO. 5-72
Report on Implementation of Resolutions Passed by the House of Delegates of the Ohio State Medical Association

"The next resolution considered by this committee was Resolution No. 5-72, submitted by the Academy of Medicine of Cincinnati. The committee felt that the Resolved portion of the resolution should be amended to read as follows:

AMENDED RESOLUTION 5-72

WHEREAS, County Medical Societies, which are component parts of the Ohio State Medical Association have had resolutions introduced and passed by Delegates of the Ohio State Medical Association; and

WHEREAS, There is no direct contact made with the respective County Medical Society concerning implementation; and

WHEREAS, Actions taken by the Ohio State Medical Association in carrying out the objectives of such a resolution require the assistance of county medical societies; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association staff develop and make available within six months a progress report to the county medical society that was successful in having such a resolution adopted by the House of Delegates of the Ohio State Medical Association, with copies of the report being sent to all county medical societies.

"The committee unanimously recommends the adoption of Resolution No. 5-72 as amended, and, Mr. President, I so move."

By official action Amended Resolution No. 5-72 was adopted.

RESOLUTION NO. 6-72
Recognition for the Association of County Medical Executives, Inc. (ACME)

"Resolution No. 6-72 was submitted by the Academy of Medicine of Cincinnati. All of the testimony heard by the committee was in favor of the adoption of the resolution.

"The committee, therefore, unanimously recommends the adoption of Resolution No. 6-72 as introduced and, Mr. President, I so move."

WHEREAS, The Executive Secretaries of counties located in the State of Ohio have formed an organization to promulgate their effectiveness to the advantage of the medical profession; and

WHEREAS, No formal recognition has been accorded to the Association of County Medical Executives, Inc., with one of its primary purposes being to cooperate with the Ohio State Medical Association to bring about a more effective organizational structure in the State of Ohio; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association formally recognize the Association of County Medical Executives, Inc.

By official action Resolution No. 6-72 was adopted.

RESOLUTION NO. 7-72
Change in Ohio State Medical Association Bylaws

"Resolution No. 7-72 was submitted by the Council of the Ohio State Medical Association. This resolution was discussed by the interested participants in the open session of the committee and there was complete agreement that the resolution embodied the necessary features to correct the inequities of the existing Bylaws of the Ohio State Medical Association.

"The committee unanimously recommends the adoption of Resolution No. 7-72 and, Mr. President, I so move."

RESOLUTION NO. 7-72

WHEREAS, Chapter 1, Section 6, of the present Bylaws of the Ohio State Medical Association presently provides as follows:

"**Section 6. Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of five years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such five year period or on January 1, 1974 whichever date is later."

WHEREAS, It has come to the attention of the Council that said section imposes a hardship upon noncitizen members of the Association who are undertaking to acquire United States citizenship, because the minimum time to acquire citizenship is often closer to six years than five years from date of filing a declaration of intention, and

WHEREAS, Ohio State Medical Association policy has been strongly to encourage membership in this Association of non-citizen physicians who seek and acquire United States citizenship within the time required by law; THEREFORE, BE IT

RESOLVED, That the Council recommend to the House of Delegates that Chapter 1, Section 6, of the Bylaws be amended as follows:

"**Section 6. Effect of Failure to Acquire United States Citizenship.** Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of six years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such six year period or on January 1, 1974 whichever date is later."

By official action Resolution No. 7-72 was adopted.

RESOLUTION NO. 15-72
Grass Roots Involvement in AMA

"Resolution No. 15-72 was submitted by the Academy of Medicine of Cleveland.

"This resolution was discussed extensively in the open and executive sessions of the committee. It was felt that the concepts which engendered the resolution were excellent but the implementation was impractical. Therefore, it is the opinion

of this committee that Resolution No. 15-72 not be adopted and, Mr. President, I so move."

RESOLUTION NO. 15-72

WHEREAS, Criticism has been made by members of the American Medical Association that their views and wishes are not being expressed, and

WHEREAS, The real strength of the American Medical Association must be in the representation of the views and wishes of the majority of its physician members, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association Delegates and Alternate Delegates to the AMA be instructed to survey the component societies of this State to ascertain their opinion on major issues and resolutions before the House of Delegates of the AMA, and BE IT FURTHER

RESOLVED, That this principle also be introduced in a resolution at the House of Delegates of the AMA.

By official action **the House voted to reject Resolution No. 15-72.**

RESOLUTION NO. 25-72
Proposed Amendment to the Bylaws of the Ohio State Medical Association

"Resolution No. 25-72 was submitted by delegates Joseph Bonta, M.D., Columbus and Thomas Morgan, M.D., Gallipolis.

"The committee was in complete agreement with the resolution after excellent presentations by Dr. Bonta and other interested members at the open session of the committee meeting. The committee felt, however, that the resolution needed to be modified and amended, and submits for the approval of the House of Delegates the following amended resolution:

AMENDED RESOLUTION NO. 25-72

WHEREAS, The present Bylaws of the Ohio State Medical Association now require that every resolution to be presented to the House of Delegates shall be filed with the Executive Director of the Association at least sixty (60) days prior to the Annual Meeting of the House of Delegates; and

WHEREAS, There have been increasing numbers of "Emergency Resolutions" presented at the opening session of the House of Delegates; and

WHEREAS, These "Emergency Resolutions" can be considered by the House of Delegates only if the reasons for the late submission are favorably considered by two-thirds (⅔) of the delegates present at the opening session; and

WHEREAS, The substance of any "Emergency Resolution" is not to be considered by the House of Delegates until the filing and transmittal requirements have been waived; and

WHEREAS, There has been a great tendency for the discussion by the members of the House of Delegates to concern itself with the substance of the resolution itself rather than with the reasons why it should or should not be declared an "Emergency Resolution," and

WHEREAS, An inordinate amount of time has been consumed in recent years at the meeting of the House of Delegates in deciding whether reasons for the late submission of these resolutions are acceptable to the House; and

WHEREAS, A more orderly procedure would be accomplished if "Emergency Resolutions" were submitted to a Special Committee on Emergency Resolutions of the House of Delegates for the purpose of deciding whether or not the filing and transmittal requirements are to be waived;

IT IS, THEREFORE, proposed that the second sentence of Chapter 4, Section 8 of the Bylaws of the Ohio State Medical Association be amended to read as follows:

> No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been compiled with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This Special Committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

"Mr. President, the committee unanimously recommends the adoption of Amended Resolution No. 25-72, and I so move."

By official action **Amended Resolution No. 25-72 was adopted.**

RESOLUTION NO. 30-72
Assessment for Preservation of Constitutional Rights

"This resolution was submitted by the Huron County Medical Society.

"The committee felt that this resolution was not acceptable. No one appeared before the committee urging the adoption of this resolution. The committee recommends that Resolution No. 30-72 not be adopted and, Mr. President, I so move."

WHEREAS, Political Leaders seek to gain political power through National Health Insurance, and Socialized Medicine; and,

WHEREAS, The various proposed plans and schemes would in fact establish rationing of health services — not according to the patient's need, but rather — according to government's fiscal budget, and possible political expediencies, and;

WHEREAS, Through these schemes, these same proponents would continue to harass, vilify, and misinform the public concerning Private Practicing Physicians — even to the extent of divesting Private Practicing Physicians of their Constitutional Rights; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association assess each member $10.00 (ten dollars) yearly to provide funds to employ additional legal counsel to:

a. Continue to protect vigilantly the concept of the Private Practice of Medicine, and,
b. Defend the Constitutional Rights of members of the Ohio State Medical Association against possible intrusion, violation and/or negation of same by third party fiats — including government.

By official action **the House voted to reject Resolution No. 30-72.**

(Continued on Next Page)

RESOLUTION NO. 31-72
Involuntary Servitude

"Resolution No. 31-72 was submitted by the Huron County Medical Society.

"This resolution was considered by Resolutions Committee No. 3 and the committee wishes to express its appreciation to the several members of the House of Delegates who gave opinions concerning this resolution. It particularly valued the opinion of Dr. Donald E. Wood, of the American Medical Association Board of Trustees, speaking by invitation of the committee, who assured us that the AMA at the present time is already carrying out the intent of this resolution and that the resolution, therefore, would be superfluous and should not be adopted. This was the unanimous opinion of the committee, which recommends that Resolution No. 31-72 not be adopted and, Mr. President, I so move."

RESOLUTION NO. 31-72

WHEREAS, The Federal Price Commission states: "No noninstitutional provider of health services may adopt any change in charging practices, reduction in quality or quantity of services, or any other practice for the purpose of avoiding compliance with any provision of this section." THEREFORE, BE IT,

RESOLVED, That the Ohio State Medical Association House of Delegates request legal counsel of OSMA and/or AMA to request proper legal authorities — including The United States Supreme Court, if necessary, to rule on the constitutionality of the above seemingly unconstitutional mandate and possible violation of Article XIII of Amendments to the United States Constitution by the Price Commission.

By official action **the House voted to reject Resolution No. 31-72.**

RESOLUTION NO. 37-72
Nationwide Educational Campaign

"Resolution No. 37-72 was submitted by the Huron County Medical Society.

"Testimony presented to the committee suggested that the requested action in the resolution was not within the scope or consistent with the purposes of the American Medical Political Action Committee.

"It was, therefore, the unanimous opinion of the committee that Resolution No. 37-72 should not be adopted and, Mr. President, I so move."

RESOLUTION NO. 37-72

WHEREAS, Extensive propaganda campaigns to nationalize medicine have been conducted, in the past several years, by government, labor unions, political leaders, and other organizations, THEREFORE, BE IT

RESOLVED, That the American Medical Political Action Committee expend a sufficient amount, perhaps fifty per cent of its funds, to launch persistent and continuing national educational efforts by radio, television, newspapers, and whatever ways it deems feasible to acquaint the public with the evils resulting from socialized medicine — to patients, doctors, and the Nation in general.

By official action **the House voted to reject Resolution No. 37-72.**

RESOLUTION NO. 38-72
AMA Reorganization

"Resolution No. 38-72 was submitted by the Council of the Lake County Medical Society.

"This resolution was not considered by this Resolutions Committee because it merely stated that a component society endorsed a particular action. It did not request or require any action or evaluation by this committee or by the House of Delegates, so no action was taken on Resolution No. 38-72.

RESOLUTION NO. 38-72

WHEREAS, We, the Lake County Medical Society, hold the opinion that the hierarchy of the American Medical Association has not and does not consistently represent the feelings and intent of the majority of the individual, practicing, physician members, and

WHEREAS, The American Medical Association because of this practice, is in a state of ill health, and

WHEREAS, The national president Wesley Hall, M.D. has stated that a review is needed for the purpose of
a. A constitutional change
b. A restructuring of the organization of the American Medical Association
c. A fresh delineation of committee responsibility within the American Medical Association,
and to redirect the aim of the American Medical Association to health care, THEREFORE, BE IT

RESOLVED, That the Lake County Medical Society endorses and wholly supports the action and purpose of Wesley Hall, M.D. in this endeavor.

The House accepted Resolution No. 38-72 for information only.

RESOLUTION NO. 39-72
Unit Rule

"Resolution No. 39-72 concerning Unit Rule, presented by the Lake County Medical Society, occasioned much discussion and sometimes rather heated debate. The committee's course of action was assisted by the appearance of the State Association's legal counsel, at the request of the committee, and during the ensuing discussion he pointed out some pertinent principles from the *Standard Code of Parliamentary Procedure* by Alice Sturgis, which states at page 140: 'A member of any democratic body has the right to express his will or preference in electing officers and in deciding propositions. The right to a voice in determining the will of an assembly is the most fundamental right of a member.' Accordingly, the committee unanimously voted to recommend that the House of Delegates approve the principle that the Unit Rule should not be utilized in the conduct of the business of the Ohio State Medical Association. It was felt that with approval of this recommendation Resolution No. 39-72 becomes

superfluous and it was the opinion of this committee that Resolution No. 39-72 not be adopted and, Mr. President, I so move."

RESOLUTION NO. 39-72

WHEREAS, Dissatisfaction is expressed at the lack of responsiveness of Medical Association hierarchial authority to requests from less influential members, and

WHEREAS, "Unit Rule" tends further to result in the negation of the minority voice of those delegates and alternate delegates who represent the members in less populous counties, THEREFORE, BE IT

RESOLVED, That the business of the Ohio State Medical Association in all respects be conducted henceforth without resort to the "Unit Rule," and BE IT FURTHER

RESOLVED, That this resolution be posed to the American Medical Association in a form suitable for adoption nationally.

By official action the House of Delegates voted **to approve the principle that the Unit Rule should not be utilized in the conduct of the business of the Ohio State Medical Association.**

By official action **the House voted to reject Resolution No. 39-72.**

RESOLUTION NO. 46-72
Dissolution of the American Board of Nuclear Medicine

"Resolution No. 46-72 was submitted by James Tye, M.D., Dayton (on behalf of the Radiologists) and R. G. Thomas, M.D., Elyria (at the request of the Ohio Society of Pathologists).

"The committee soon learned that this resolution was highly controversial. It occasioned a great deal of discussion in both the general and executive sessions of the committee. The committee was equally divided as to the disposition of this resolution. After a long discussion it became evident that the problem merited further study.

"It was then moved and seconded that Resolution No. 46-72 be referred to the Council of the Ohio State Medical Association for continuing evaluation and this motion was passed unanimously by the committee.

"Mr. President, I move that the actions of this committee with regard to Resolution No. 46-72 be approved."

RESOLUTION NO. 46-72

WHEREAS, The AMA House of Delegates directed the formation of an ad hoc committee, in cooperation with the American Board of Medical Specialties, with representation from appropriate specialty societies and boards, to study the current problems related to certification in Nuclear Medicine and to suggest solutions to these problems; and,

WHEREAS, The ad hoc committee unanimously agreed to solutions and recommended them to the American Board of Medical Specialties for adoption; and,

WHEREAS, The American Board of Medical Specialties totally rejected the recommendations of the ad hoc committee, THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association recommend to the AMA House of Delegates that the actions establishing the American Board of Nuclear Medicine be rescinded since total abrogation of the recent recommendations of the House of Delegates of the American Medical Association has occurred, and BE IT FURTHER

RESOLVED, That in the light of the aforementioned developments, the House of Delegates re-examine the requirement for concurrence of the American Board of Medical Specialties in the establishment of specialty boards which have been approved by the Council on Medical Education of the House of Delegates.

By official action the recommendation of the committee was not sustained and **Resolution 46-72 was adopted.**

RESOLUTION NO. 50-72
Waiver of OSMA Dues at Age 80

"Resolution No. 50-72 was submitted by the Mahoning County Medical Society.

"The committee was the recipient of very little discussion with regard to this resolution. It took into account the introduction of previous resolutions in 1950, 1951, 1952, 1958, 1964 and 1965, all relative to waiver of dues on an age basis. It was the unanimous opinion of the committee that this resolution should not be adopted and, Mr. President, I so move."

RESOLUTION NO. 50-72

WHEREAS, The American Medical Association, and other medical organizations, do not require their members to pay dues after the age of 70, and

WHEREAS, A physician reaching the age of 80 has, in the normal course of his career, paid dues to a variety of medical organizations for a long time, and

WHEREAS, Most physicians having reached the age of 80 have limited their practice in varying degrees, and

WHEREAS, The active physicians of Ohio owe much to their colleagues who have preceded them and want to show their appreciation, and

WHEREAS, The Ohio State Medical Association has, in the past, based payment of dues on retirement, rather than age, THEREFORE, BE IT

RESOLVED, That, beginning with the collection of dues for 1973, the Ohio State Medical Association issue a waiver of dues to all members who have passed their 80th birthday in the year previous to that for which dues are being collected.

By official action **the House voted to reject Resolution No. 50-72.**

RESOLUTION NO. 55-72
Hospital Board

"Resolution No. 55-72 was submitted by the Madison County Medical Society.

"No member of the committee nor any member of the House of Delegates who appeared before the committee expressed any opinions which were in opposition to the concepts of the resolution. It was felt that the resolution should be amended to render it more specific. Therefore, the resolution was amended as follows:

AMENDED RESOLUTION NO. 55-72

WHEREAS, The American Hospital Association and the American Medical Association have been urging placement of physicians on hospital trustee boards for several years, and,

WHEREAS, There are still some appointing authorities

in Ohio who have failed to recognize the need of their community hospital, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association take whatever steps are necessary to encourage the Ohio Legislature to amend Ohio Revised Code 339.02 to mandate the presence of PRACTICING physicians as voting members on the board of trustees of hospitals that are subsidized by taxpayer's monies.

"The committee recommends the approval of Amended Resolution No. 55-72 and, Mr. President, I so move."

By official action **Amended Resolution No. 55-72 with an amendment set forth in capital letters, was adopted.**

RESOLUTION NO. 57-72
Per Diem for Delegates

"Resolution No. 57-72 was submitted by the Summit County Medical Society.

"The committee was unanimous in its opinion that this resolution was impractical, that it would never, under any circumstances, be approved by the House of Delegates and, therefore, should not be adopted. Mr. President, I so move.

WHEREAS, All OSMA physician members should share through their state association dues the expense of their representatives in this House of Delegates creating OSMA policy in service to them, and

WHEREAS, Reimbursement for out-of-pocket expenses to delegates is a serious concern to those county medical societies contributing significantly to the business of this House as is their own society expense from these annual meetings, and

WHEREAS, Reimbursement in whole or in part for delegates has been accepted by some state medical associations and by national specialty organizations, THEREFORE, BE IT

RESOLVED, That OSMA pay to those county societies seating delegates in both sessions of the annual meeting the sum of $100 per day per delegate for the number of days beginning with the date of the first session of the House and ending with the date of the last session of the House, and BE IT FURTHER

RESOLVED, That a ceiling on the budget for this expense be established at the equivalent of $2.50 for each OSMA member per day, reductions in payments to county societies being prorated accordingly if this sum does not equal the $100 per day per delegate formula.

By official action **the House voted to reject Resolution No. 57-72.**

RESOLUTION NO. 58-72
1973 Annual Meeting

"Resolution No. 58-72 was submitted by the Summit County Medical Society.

"The committee discussed at length the proposal as embodied in this resolution. Testimony was received both pro and con in the general session of the committee. During this discussion the committee was favored with the presence and remarks of the chairman of the Committee on Scientific Work. These discussions proposed the concept that the membership of the Ohio State Medical Association be periodically polled as to their desires concerning changes in the format of the Annual Meeting. This concept was enthusiastically received by the chairman of the Committee on Scientific Work, who assured us that it would be implemented in the near future. With this information available, the members of the committee felt that the passage of this resolution would not be in the best interests of the Association.

"The committee recommended that Resolution No. 58-72 not be adopted and, Mr. President, I so move."

RESOLUTION NO. 58-72

WHEREAS, All county societies were notified on January 18 of the efforts of the state Council to "shorten the length of time that the physician needs to be away from his office this year to attend the business sessions of the OSMA House of Delegates," and

WHEREAS, The first session of the House will convene on Monday morning and the second session of the House will not convene until Thursday morning, and

WHEREAS, All reference committee meetings are scheduled for Monday afternoon, BE IT THEREFORE

RESOLVED, That the business sessions of the House of Delegates at the annual meeting in 1973 be held on Sunday evening following district caucuses Sunday afternoon and on Tuesday afternoon with reference committee sessions being held Monday morning and, if necessary on Monday afternoon and Tuesday morning.

By official action **the House voted to reject Resolution No. 58-72.**

RESOLUTION NO. 60-72
Critical Need to Reevaluate Available Resources to Support Hospital-Based Training Research and Educational Programs

"Resolution No. 60-72 was submitted by Frederick P. Osgood, M.D., Delegate, Academy of Medicine of Toledo and Lucas County.

"After due deliberation and evaluation of the testimony presented at the general session and the executive session, the committee recommended that Resolution No. 60-72 be adopted as submitted, and, Mr. President, I so move."

PREAMBLE

The need for hospitals to support educational and training programs, if their facilities, staff and resources are adequate, is well-recognized. The continuant progress of medical education and research to support patient care programs is likewise recognized as a necessity.

The source of financial support of hospital-based educational and training programs, be it for licensed practical nurses, registered nurses, allied medical occupationalists, hospital administrators, interns, residents or continuing medical education for practicing staff physicians has been the hospitalized patient. Currently, the hospitalized patient is confronted with spiralling hospital bills due to increased personnel, equipment and service costs, and substantial educational costs.

It is mandatory that the medical profession undertake studies to relieve where feasible the hospitalized patient of those hospital costs assigned to support medical education, training and research programs, THEREFORE, BE IT

RESOLVED, That The Council of the Ohio State Medical Association and the proper councils of the

American Medical Association be immediately requested to undertake studies designed to develop financial resources other than those of the hospitalized patient (the patient's insurance program or the patient's supporting agency) to support educational training and research programs based in the hospital environment.

By official action **Resolution No. 60-72 was adopted.**

EMERGENCY RESOLUTION NO. 65-72
Special AMA Open Hearings

"Emergency Resolution No. 65-72 was submitted by the Fourth Councilor District and was assigned to Resolutions Committee No. 3.

"It immediately became apparent to the members of the committee that there was a great deal of emotion concerned with the principles expressed in this resolution. The committee occupied itself with this resolution for lengthy periods of time, both in the general and executive sessions. After careful and completely impartial evaluation, the committee has developed, and wishes to submit to the House of Delegates, a substitute resolution as follows:

SUBSTITUTE EMERGENCY RESOLUTION NO. 65-72

WHEREAS, The purpose of the special open hearings to be conducted by the Long Range Planning Council of the American Medical Association is to allow free expression and criticism of the Constitution and Bylaws, the organizational structure, and the committee responsibilities of the American Medical Association; THEREFORE BE IT

~~[RESOLVED, That this House of Delegates go on record as being actively opposed to, and to instruct its delegates to the American Medical Association to be actively opposed to, any procedural policies which contravene or restrict free expression by any member of the AMA before the Long Range Planning Council.]~~

RESOLVED, THAT THIS HOUSE OF DELEGATES GO ON RECORD AS ENDORSING THE TRADITIONAL PROCEDURAL POLICIES WHICH PROVIDE FREE EXPRESSION BY ANY MEMBER OF THE AMERICAN MEDICAL ASSOCIATION BEFORE AMA COMMITTEES AND COUNCILS, AND BE IT FURTHER

RESOLVED, THAT THIS RESOLUTION BE FORWARDED TO THE EXECUTIVE-VICE-PRESIDENT OF THE AMA, TO THE SPEAKER OF THE HOUSE, AND THROUGH THEM TO THE LONG RANGE PLANNING COUNCIL.

"Mr. President, the committee recommends the adoption of Substitute Emergency Resolution No. 65-72, and I so move."

By official action the House struck out the resolved portion of the Substitute Emergency resolution and inserted the wording set forth in Capital letters. **Amended Substitute Emergency Resolution 65-72 was then adopted.**

REPORT OF THE OHIO STATE MEDICAL ASSOCIATION COMMISSION ON MEDICAL EDUCATION

(Re: Resolution No. 3-71, Continuing Education as a Requirement for Membership in the Ohio State Medical Association)

"Resolutions Committee No. 3 next concerned itself with the report of the Commission on Medical Education.

"The committee thoroughly reviewed the Commission's report and was extremely impressed with the effort and work of the Commission. It is the unanimous recommendation of the committee that the report of the Commission be accepted by the House of Delegates, and, Mr. President, I so move."

The report appears beginning on page 687 of this issue of *The Journal.*

"It is the further unanimous recommendation of this committee that a Commission on Medical Education should continue to function. The committee suggests that the Commission devise a method for evaluation of the Association's members' present involvement with continuing medical education as well as their future interests therein.

"The committee recommends that this Commission again report to the House of Delegates at the Annual Meeting of the Ohio State Medical Association in 1973."

By official action **the House voted to adopt the Report of the Commission on Education.**

"I wish to express my personal appreciation to the members of the committee for their patience, intelligence and for their thoughtful consideration of the matters presented for their deliberation, and to thank all of the members who appeared before the committee and presented their opinions.

"I wish also to acknowledge the helpful services of the legal counsel of the Association and to express my thanks to the executive staff and the secretarial staff of the Association for their invaluable help.

"This report respectfully submitted by the following members of Resolutions Committee No. 3: Milton W. Gwinner, Hamilton County; George J. Schroer, Shelby County; John A. Glorioso, Allen County; Benjamin H. Reed, Jr., Fulton County; Clarence L. Huggins, Cuyahoga County; Edward E. Grable, Stark County; Robert R. Johnson, Coshocton County; James A. L. Toland, Guernsey County; John W. Zimmerly, Jackson

County; Robert W. Jones, Richland County; Jasper M. Hedges, Pickaway County, Chairman.

"The Report of Resolutions Committee No. 3 as a whole, as amended, was adopted."

Report of Resolutions Committee No. 4

Dr. Homer A. Anderson, Franklin County, reported for Resolutions Committee No. 4 of which he was chairman. The report read as follows:

"Resolutions Committee No. 4 held hearings on nine resolutions. The discussion in the Committee meeting was thorough—and adequate discussion was held on all resolutions.

RESOLUTION NO. 8-72
Liaison with Medical Board

"The Committee felt the resolution should not be adopted because: (1) it is now being done, (2) some of the material will be covered with the peer review resolutions, and (3) some of this resolve was covered in last year's Resolution No. 23-71 entitled 'Malpractice Crisis.'

"Mr. President, we recommend that Resolution 8-72 not be adopted and I so move."

RESOLUTION NO. 8-72

WHEREAS, The Membership of the Ohio State Medical Association is becoming more concerned about the increasing numbers of malpractice suits; and

WHEREAS, Some few practitioners of medicine have not been adequately disciplined for true malpractice; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association pursue the effecting of a closer liaison between itself and the Ohio State Medical Board with the intention of reviewing the cases in which the physician has been found incompetent or negligent, and institute appropriate action.

By official action **the House voted to reject Resolution No. 8-72.**

RESOLUTION NO. 9-72
Proposed Solution to Current Malpractice Problem

"The Committee felt that the resolution should be adopted in principle but amended to include the word "implement" in the resolved section, thus reading:

AMENDED RESOLUTION NO. 9-72

WHEREAS, The Membership of Ohio State Medical Association is becoming more concerned about the increasing numbers of malpractice lawsuits and greater negotiated settlements of these suits; and

WHEREAS, The Membership believes many of these suits to be without foundation; and

WHEREAS, The present legal system of adversary trial before jury of non-expert laymen is often ineffectual in arriving at justice based on truth and fact for both the patient plaintiff and physician defendant; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Council of the Ohio State Medical Association to find and implement other means of resolving malpractice claims, especially by the use of arbitration boards and/or by special juries of experts and also to explore the feasibility of developing a system of settlement such as a compensation board.

"Mr. President, we recommend the adoption of Resolution No. 9-72 as amended and I so move."

By official action **Amended Resolution No. 9-72 was adopted.**

RESOLUTION NO. 10-72
Attorneys' Contingeney Fees in Relation to Current Malpractice Problems

"This resolution submitted by the Academy of Medicine of Cincinnati requires amending to provide for some additional material.

AMENDED RESOLUTION NO. 10-72

WHEREAS, The Membership of the Ohio State Medical Association is becoming more concerned about the increasing number of malpractice lawsuits, and negotiated settlements of these law suits; and

WHEREAS, The Membership believes many of these claims and lawsuits to be without foundation; and

WHEREAS, The contingency fee method of attorney's compensation encourages the filing of unjustified claims against hospitals, physicians and allied personnel without the plaintiff incurring any financial responsibility; THEREFORE BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association strongly oppose the contingency fee concept IN MEDICAL LIABILITY; and BE IT FURTHER

RESOLVED, That the House of Delegates of the Ohio State Medical Association instruct the Council of the Ohio State Medical Association to investigate the feasibility of introducing a bill in the Ohio State Legislature to control or restrict excessive compensation of attorneys through the contingency fee system in medical liability actions.

"Mr. President, the Committee recommends the adoption of Amended Resolution No. 10-72, and I so move."

By official action the House **voted to Amend and to refer Resolution No. 10-72 to the Ohio State Medical Association—Ohio State Bar Association Liaison Committee.**

RESOLUTION NO 14-72
Poliey Statement on Alcoholism

"The Committee recommends the adoption of this resolution as submitted with one minor change, i.e., delete the quotation marks around disease in the underscored portion of the text since we believe alcoholism is now generally recognized as a disease.

AMENDED RESOLUTION NO. 14-72
(By the Academy of Medicine of Cleveland)

WHEREAS, The House of Delegates of the American Medical Association adopted a new AMA Policy Statement on Alcoholism at the Clinical Session of the House 1971 (Report G of the Board of Trustees), and

WHEREAS, This statement does not explicitly recognize

the need for non-medical facilities for rehabilitation and follow-up care, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association delegation to the American Medical Association be instructed to submit the following amendment to the AMA Policy Statement on Alcoholism so that it will read as follows:

RESOLVED, That the American Medical Association identifies alcoholism as a complex disease with biological, psychological and sociological components and recognizes medicine's responsibility in behalf of affected persons. The Association recognizes that there are multiple forms of alcoholism, and that each patient should be evaluated and treated in an individualized and comprehensive manner. *It should also be recognized that even though the reason for hospital admissions may be medical, the success of any treatment program will depend on ultimate referral to non-medical facilities for rehabilitation and follow-up care directed toward the psychological and sociological components of this disease. By early recognition of drinking problems prior to biological injury, non-medical treatment of the psychological and sociological components may obviate the need for medical care.

(*The new material requested by the resolution occurs from the asterisk to end of resolution)

"The Committee unanimously recommends the adoption of Resolution No. 14-72 as amended and, Mr. President, I so move."

By official action the House voted to adopt **Amended Resolution No. 14-72.**

RESOLUTION NO. 22-72
Annual Chest X-ray Exams

"This resolution was submitted by the Defiance County Medical Society and the Committee felt it should be rewritten in order to express the ideas of the majority of those who testified before the Committee. Great concern was expressed because of the unnecessary radiation provided by mobile x-ray units and the danger associated with photofluorogram. Inasmuch as the resolution concerned itself only with cosmetologists, concern was expressed over the undue use of radiation among other groups constituting a public health hazard. The following is our substitute resolution.

SUBSTITUTE RESOLUTION NO. 22-72

WHEREAS, The Ohio Board of Cosmetology requires an annual physical examination of beauty shop operators and as a part of this physical examination an annual chest x-ray examination is also required, and, in view of the following facts, namely,

1. That there is a low incidence of pulmonary tuberculosis in Ohio, and
2. That there is no scientific evidence that the contact between an operator and customer constitutes a significant communicable disease health hazard greater than that which may exist in many other occupations and professions, and
3. That other similar personal contact occupations and professions are exempt from this requirement, and
4. That an annual chest x-ray examination adds to the total radiation dose of the individual which is cumulative throughout his lifetime, and
5. That the cost is borne entirely by the operator, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association petition the Board of Cosmetology that the requirement of an annual chest x-ray is an unnecessary cost and an unnecessary exposure to x-radiation and thus that this portion of the required periodic examination be modified by the use of annual tuberculin skin testing program or 14″ by 17″ chest x-ray where indicated.

"The Committee recommends that Substitute Resolution No. 22-72 be adopted, and Mr. President I so move."

By official action **Substitute Resolution No. 22-72 was adopted.**

RESOLUTION NO. 47-72
Homicide by Handguns

(Academy of Medicine of Toledo and Lucas County)

"There was some question as to whether this resolution was within the scope of the medical profession—but it was decided by the Committee that as physicians, and as concerned citizens, and as those involved in the care of these victims, we have a legitimate concern in this area. We deleted the first resolved because the committee felt that we have no intention to interfere with the rights of law-abiding citizens to own firearms. Therefore, we submit the following amended resolution.

AMENDED RESOLUTION NO. 47-72

WHEREAS, Homicide by means of firearms has increased to serious proportions and realizing the inadequacy of any one control but impelled by the urgency of the situation to make a forward step, statewide and nationally; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association support legislation which provides for mandatory jail sentence for those found guilty of committing or threatening to commit a misdemeanor or felony involving the use of a firearm; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association direct its delegates to the American Medical Association to convey this resolution to that body and work for American Medical Association endorsement of national legislation to [~~effect control of this problem.~~] PROVIDE FOR SAID JAIL SENTENCE.

"Mr. President, I move the adoption of Amended Resolution No. 47-72."

By official action the House **voted to amend Amended Resolution No. 47-72 as indicated by the strike-out deletions, and by the addition set forth in capital letters, then adopted it.**

RESOLUTION NO. 51-72
Non-Therapeutic Use of Drugs by Athletes

"It is suggested by this Committee that the words "pharmacological agents" be used instead of "drugs" in this resolution. It was decided that another resolve be added to make this resolution known to the people most likely to have control over this situation. Therefore, we submit the following amended resolution.

AMENDED RFSOLUTION NO. 51-72
Non-Therapeutic Use of Pharmacological Agents by Athletes

WHEREAS, The non-therapeutic use of pharmacological agents to improve performance in athletics, commonly

known as "doping," is reported to be increasing in the college and high school age population; and

WHEREAS, Such use of pharmacological agents to enhance performance is contrary to the health, social and ethnical objectives of sports; and

WHEREAS, The Ohio State Medical Association strongly reaffirms its absolute condemnation of the non-therapeutic use of these agents by athletes and authorization of the use of such medication by those who provide health care for athletes; BE IT FURTHER

RESOLVED, That all members of the Ohio State Medical Association exert rigid control of the prescription of stimulant and sedative drugs and androgenic-anabolic steroids to athletes or to those who might put such agents into the hands of athletes; BE IT FURTHER

RESOLVED, That representatives of the Ohio State Medical Association introduce this resolution into the House of Delegates of the American Medical Association at the next Annual Meeting of the Association; BE IT FURTHER

RESOLVED, That a copy of this resolution be widely publicized and distributed and that a copy of such be sent to all coaches, trainers, and all persons associated with athletes.

"Mr. President, we recommend that Amended Resolution No. 51-72 be adopted as amended and I so move."

By official action, **Amended Resolution No. 51-72 was adopted.**

RESOLUTION NO. 52-72
Phenylketonuria
(By the Madison County Medical Society)

"The Committee believes they do not have adequate information or statistics to make a recommendation to the House. The committee further believes, however, that the subject should be further investigated and, therefore, recommends that this resolution be referred to Council for appropriate action. I move that 52-72 be referred to Council."

RESOLUTION NO. 52-72

WHEREAS, The Phenylketonuria (PKU) test on newborns as mandated by Ohio law is expensive with minimal (percentage wise) results, and

WHEREAS, Other genetic-linked and non-genetic diseases of metabolic error can be recognized by similar techniques at the same time, THEREFORE, BE IT

RESOLVED, That the law making PKU test mandatory be repealed entirely or that it be amended to include those other in-born errors of metabolic diseases that can be so recognized at this time.

By official action **Resolution No. 52-72 was referred to the Council.**

RESOLUTION NO. 53-72
Scotochromogen
(By the Madison County Medical Society)

"Our Committee believes this resolution should be rejected for the following reasons: (1) because this group of bacteria is rare, is not communicable but is considered a pathogen, and (2) because any delay in proper diagnoses constitutes a hazard and prevents adequate followup in true acid fast infections, and (3) because Public Health officials would prefer to have this disease reported for statistical purposes.

"Mr. President, it is our recommendation that this resolution be rejected, and I so move."

RESOLUTION NO. 53-72

WHEREAS, Ohio law requires that the acid fast bacilli known as Scotochromogen Runyon Group II be treated exactly as acid fast tubercle bacilli when it is not a pathogen per se, THEREFORE, BE IT

RESOLVED, That the OSMA instrument the necessary mechanism to have the law changed to exclude Runyon Group II from the reportable contagious class of pathogens.

By official action **the House voted to reject Resolution No. 53-72.**

"I wish to express my sincere thanks and appreciation to all members of my Committee for their thoughtful consideration of all resolutions; to the legal counsel, Mr. James Pohlman, for reviewing this report; to all those who presented testimony lending their insight and wisdom to the individual resolutions under discussion; and to both the executive and secretarial staff of the Ohio State Medical Association.

"This report respectfully submitted by the following members of Resolutions Committee No. 4: Thomas E. Fox, Warren County; William G. Cassel, Montgomery County; Robert S. Oyer, Auglaize County; William H. Roberts, Wood County; Wesley J. Pignolet, Lake County; Rocco Antenucci, Summit County; German Ortiz, Belmont County; Irving A. Nickerson, Licking County; Walter A. Daniel, Seneca County; Richard W. Avery, Medina County; Homer A. Anderson, Franklin County Chairman.

"Mr. President, I move the adoption of the Report of Amended Resolutions Committee No. 4 as a whole."

The report of Resolution Committee No. 4 as a whole, as amended, was adopted.

Inaugural Ceremony

Dr. Richard L. Fulton, past president, Columbus presented the traditional silver tray to Dr. and Mrs. P. John Robechek and certificate of honor to Dr. Robechek the retiring president.

Dr. Fulton administered the presidential oath of office to Dr. William R. Schultz. Retiring president Robechek presented the official gavel to incoming President Schultz.

Dr. Robechek received the past president's pin from Dr. Schultz.

Dr. Schultz presented before the House of

Delegates his Inaugural Address. (Text of address on page 696).

Committees Named

Dr. Schultz presented the following committee appointments and they were officially approved by the House of Delegates:

Committee on Education — Dr. John G. Sholl, Cleveland, reappointed chairman for the ensuing year; Dr. Calvin F. Warner, Cincinnati, reappointed for a term of five years, 1972-1977.

Committee on Judicial and Professional Relations — Dr. Homer A. Anderson, Columbus, reappointed chairman for the ensuing year; Dr. Lawrence C. Meredith, Oberlin, appointed for a term of five years, 1972-1977.

Committee on Membership and Planning — Dr. William M. Wells, Newark, appointed chairman for ensuing year; Dr. Richard S. Graves, Dayton, appointed for a term of five years, 1972-1977.

Committee on Public Relations — Dr. Luther W. High, M.D., Millersburg, reappointed chairman for the ensuing year; Dr. Wendell M. Bell, Mansfield, appointed for a term of five years, 1972-1977.

Committee on Scientific Work — Dr. Robert E. Zipf, Dayton, reappointed chairman for the ensuing year; Dr. John E. Albers, Cincinnati, reappointed for a term of five years, 1972-1977; Dr. John A. Prior, Columbus, reappointed for a term of five years, 1972-1977; Dr. Robert Young, Johnstown, appointed for a term of two years, 1972-1974, to fill the unexpired term of Dr. Roland Kennedy, Toledo.

There being no further business, the House of Delegates then adjourned sine die.

ATTEST: Hart F. Page
Executive Director

Report of the OSMA Commission on Medical Education

To: The Council of the Ohio State Medical Association
From: The Ohio State Medical Association Commission on Medical Education
Subject: Resolution No. 3-71, Continuing Education as a Requirement for Membership in OSMA

Gentlemen:

Resolution 3-71 contains the following House of Delegates directive to The Council:

RESOLVED, that this House direct The Council of the Ohio State Medical Association to conduct a study of methods of implementing Continuing Medical Education Programs as a requirement for continuing membership in the OSMA and that these findings be presented to the 1972 session of the House of Delegates for definitive action then.

From the onset, the Commission has assumed that, while the resolution referred to "continuing Medical Education **Programs**" as a membership requirement, the intent of the resolution and of the House was to mean continuing medical education **participation** by OSMA members. Several hundred man hours have been expended in this project.

The Commission on Medical Education has explored the subject in great depth, holding several full meetings, several committee and subcommittee meetings, and explorations with other state and national organizations.

The Commission, among other items, has conducted a survey of all other state associations as to their continuing education involvements and requirements.

There have been several discussions with American Medical Association Council on Medical Education staff members involved in continuing education programs. These persons expressed considerable interest in our studies and offered full cooperation in any venture we might undertake.

The Commission has encountered some formidable questions in its studies of the issue. Some of these questions are:

In the concept that medical education is a lifelong curriculum, what kinds of programs could be developed, or approved, as meaningful and useful to the practicing physician?

Physicians are independent and individualistic by nature of their profession. What would be the reaction of physicians who must comply or lose their membership in OSMA?

AMA Council on Medical Education staff members estimate that at least one staff executive and one or two secretaries would be required *full time* to administer a mandatory continuing education program for an Association as large as OSMA. Costs are estimated at an absolute minimum of $10 per member. It therefore definitely

would require a dues increase to finance this program. Is the House of Delegates prepared to vote a dues increase earmarked for the program?

What methods would be used to "accredit" continuing education sessions as applicable toward meeting continuing education requirements?

Would a voluntary program be more feasible and more acceptable to the membership than would mandatory participation?

What types of educational activities would be most meaningful to practicing physicians?

Continuing Education Not New

As was noted in the opening remarks in this statement, medicine is a lifetime curriculum. No other profession devotes so much of its time, attention, self-examination and talents to continuing education. The public, with government agencies and legislators in particular, is woefully unaware of the immense scope of medicine's continuing education participation.

What is being considered here, rather than being a new facet of medicine, is a plan for organizing and recognizing existing facets to provide (1) better coordination of and participation in continuing education experiences and (2) proper professional and public recognition of the physician's participation.

Program Alternatives

It is the consensus of the Commission on Education that the House of Delegates should make the final decision as to the type of continuing education requirements — mandatory or voluntary — to be established.

The Commission recommends to The Council that the House be informed of all these ramifications and considerations before the House makes final decision in this matter.

There are various types of continuing education plans that the House might wish to consider, ranging from:

1. A mandatory participation program requiring full attendance at continuing education sessions "accredited" by the Association, with loss of membership for failure to meet the continuing education requirements.

2. A mandatory participation program requiring a number of cumulative credits during a stated period, recognizing any education program conducted by a recognized medical group, such as OSMA's Annual Meeting, AMA meetings, national or state specialty society meetings, etc., so long as the meetings are planned and conducted by the medical profession.

3. A voluntary program whereby participation requiring a number of credits or hours over a stated period, with recognition of courses approved or presented by acceptable medical groups, self-assessment, peer review,* or other educational activities, for which the qualifying physician might receive a certificate, for example, designating him as a "Fellow of the Ohio State Medical Association", with continuance of such fellowship contingent upon periodic renewal of his certification.

4. A voluntary program whereby the OSMA member receives from OSMA a certificate of commendation after the physician documents that he has met specific continuing education requirements.

Comments

In considering these alternatives, the Commission strongly recommends that consideration be given the following:

1. Great care must be given so that any program adopted does not discourage OSMA membership.

2. Ohio's four medical schools should be invited to participate in any plan. This invitation also should be extended to county societies, hospital staffs and specialty societies.

3. Serious consideration should be given to changing the OSMA Annual Meeting format to provide more in-depth continuing education experiences. (The Commission notes and compliments the Committee on Scientific Work for a major step in that direction for the 1972 Annual Meeting).

4. It would seem logical that any program adopted offer the variety of educational experiences necessary to meet the varying needs of different areas of Ohio.

The Commission would welcome the opportunity to develop and administer a continuing education program approved by the House.

Summary

The Commission on Medical Education has received and studied Resolution 3-71. It has examined programs of other state associations and other organizations. It has considered the ramifications of various types of continuing education programs. The Commission has recommended that the final decision as to the type of program, with due consideration of costs and staffing, be determined by the House of Delegates, with the Commission responsible for developing and administering that program selected by the House of Delegates.

Respectfully Submitted by the
Commission on Medical Education
March 26, 1972

(*"peer review" refers to an education review by a physician's peers)

ATTENDANCE OF DELEGATES
OSMA House of Delegates
1972 ANNUAL MEETING

County	Delegate	First Session	Final Session
	FIRST DISTRICT		
ADAMS	Francis L. Stevens	x	x
BROWN	John R. Donohoo	x	x
BUTLER	Robert P. Johnson	x	x
	James M. Smith		x
	James F. Stewart	x	x
CLERMONT	Carl A. Minning	x	x
CLINTON	Foster J. Boyd	x	x
HAMILTON	Ambrose H. Clement	x	
	Frank P. Cleveland	x	x
	Joseph G. Crotty	x	x
	William R. Culbertson	x	x
	George D. J. Griffin		x
	Milton W. Gwinner	x	x
	Charles D. Feuss, Jr.		x
	Robert S. Heidt	x	x
	Harry K. Hines	x	x
	Stephen P. Hogg	x	x
	Marvin McClellan	x	
	Glenn W. Pfister, Jr.	x	x
	Clyde S. Roof	x	
	Albert E. Thielen	x	x
	Andrew J. Weiss	x	x
	William J. Schrimpf		x
HIGHLAND			
WARREN	Thomas E. Fox	x	x
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	x	x
CLARK	Henry A. Diederichs		x
	Ernest H. Winterhoff	x	x
	Dale E. French	x	
DARKE	Delbert Blickenstaff		
GREENE	Roger C. Henderson	x	x
MIAMI	Jerry L. Hammon	x	x
MONTGOMERY	Konrad Kircher	x	x
	William G. Cassel	x	x
	A. J. Gabriele	x	x
	W. J. Lewis	x	x
	Don E. Sando	x	x
	Theodore Light	x	x
	Robert E. Zipf	x	x
PREBLE	Chester J. Brian		
SHELBY	George J. Schroer	x	x
	THIRD DISTRICT		
ALLEN	Thomas L. Edwards	x	x
	John A. Glorioso	x	x
AUGLAIZE	Robert S. Oyer	x	x
CRAWFORD	T. D. Sawyer	x	x
HANCOCK	John C. Smithson	x	x
HARDIN	Robert B. Elliott	x	x
LOGAN	James Steiner	x	x
MARION	Paul E. Lyon	x	x
MERCER	James J. Otis	x	x
SENECA	Walter A. Daniel	x	x
VAN WERT	A. C. Diller	x	x
WYANDOT	Konstantine K. Solacoff		
	FOURTH DISTRICT		
DEFIANCE	Paul E. Brose	x	
	Nicolas E. Balmoria		x
FULTON	Benjamin H. Reed, Jr.	x	x
HENRY	Reynaldo C. Soriano		x
	Thomas F. Moriarty	x	
LUCAS	C. Douglass Ford	x	x
	Roland A. Gandy, Jr.	x	x
	Bernard L. Huffman, Jr.	x	x
	William G. Henry		x
	Harry C. Mack	x	
	Frederick P. Osgood	x	x
	Howard E. Smith	x	x
OTTAWA	John F. Bodie	x	x
PAULDING	Doyt E. Farling	x	x
PUTNAM	John R. Brown		x
	James B. Overmier	x	
SANDUSKY	Willis L. Damschroder	x	x
WILLIAMS	John E. Moats		x
WOOD	William H. Roberts	x	
	Paul F. Orr		x
	FIFTH DISTRICT		
ASHTABULA	Shepard A. Burroughs	x	x
CUYAHOGA	James O. Barr	x	x
	Joseph L. Bilton	x	x
	Matthew R. Biscotti	x	x
	William F. Boukalik		x
	John H. Budd	x	x
	Leonard Lovshin	x	
	Henry A. Crawford	x	x
	Nicholas DePiero	x	x
	John J. Gaughan	x	x
	Clarence L. Huggins		x
	Roscoe J. Kennedy	x	x
	John A. Kmieck	x	x
	Vincent T. LaMaida	x	x
	George P. Leicht	x	x
	Hermann Menges, Jr.	x	x
	James R. O'Malley	x	
	George W. Petznick	x	x
	John H. Sanders	x	x
	Adolph B. Schneider, Jr.	x	x
	Frederick T. Suppes	x	x
	William V. Trowbridge	x	x
	Howard S. VanOrdstrand	x	x
	Julius Wolkin	x	x
	E. Peter Coppedge, Jr.	x	x
GEAUGA	Arturo J. Dimaculangan		x
	Alton W. Behm	x	
LAKE	Carl G. Madsen, Jr.	x	x
	Wesley J. Pignolet	x	x

(Continued on Next Page)

Attendance of Delegates (contd.)

County	Delegate	First Session	Final Session
	SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	x	x
MAHONING	John C. Melnick	x	x
	Felix A. Pesa	x	x
	Charles E. Pichette	x	x
	Jack Schreiber	x	x
PORTAGE	John F. Fulton	x	x
STARK	William D. Baker		x
	E. Joel Davis	x	x
	Edward E. Grable	x	x
	William A. White, Jr.	x	x
	C. M. King	x	
SUMMIT	R. M. Antenucci	x	x
	Robert R. Clark	x	x
	Charles V. Bowen, Jr.		x
	Richard H. Champion	x	x
	A. Dobkin		x
	Joseph Kloss	x	
	James G. Roberts	x	
	Thomas F. Ulrich	x	x
TRUMBULL	Joseph L. Logan	x	x
	Robert J. Paul	x	x
	SEVENTH DISTRICT		
BELMONT	German Ortiz	x	x
CARROLL	Carl A. Lincke	x	x
COSHOCTON	Robert R. Johnson	x	x
HARRISON	Elias Freeman	x	x
JEFFERSON	Francis A. Sunseri		x
MONROE	Byron Gillespie		
TUSCARAWAS	Robert E. Rinderknecht	x	x
	EIGHTH DISTRICT		
ATHENS	Leland P. Randles	x	x
FAIRFIELD	Richard E. Hartle		x
	Donald B. Nichols	x	
GUERNSEY	James A. L. Toland	x	x
LICKING	Irving A. Nickerson	x	x
MORGAN	Austin A. Coulson		
MUSKINGUM	Walter B. Devine	x	x
NOBLE	Edward G. Ditch		
PERRY	Ralph E. Herendeen, Jr.		
WASHINGTON	Gregory B. Krivchenia	x	x
	NINTH DISTRICT		
GALLIA	Thomas W. Morgan	x	x
HOCKING	L. W. Starr		
JACKSON	Carl J. Greever		x
	John W. Zimmerly	x	
LAWRENCE	Harry Nenni	x	x
MEIGS	Roger P. Daniels	x	x
PIKE	Albert M. Shrader		
SCIOTO	James P. McAfee	x	x
VINTON			

County	Delegate	First Session	Final Session
	TENTH DISTRICT		
DELAWARE	Robert S. Caulkins, Jr.	x	x
FAYETTE	Robert A. Heiny		
FRANKLIN	Homer A. Anderson	x	x
	Michael A. Anthony	x	x
	Joseph A. Bonta	x	
	James C. Good		x
	John N. Meagher	x	x
	Jack W. Miles	x	x
	H. William Porterfield	x	x
	Mark L. Saylor	x	x
	Donald W. Traphagen	x	x
	James H. Williams	x	x
KNOX	Henry T. Lapp	x	x
MADISON	Sol Maggied	x	x
MORROW	Joseph P. Ingmire	x	x
PICKAWAY	Jasper M. Hedges	x	x
ROSS	Joseph McKell	x	x
UNION	Paul R. Zaugg		
	ELEVENTH DISTRICT		
ASHLAND	Jon H. Cooperrider	x	
	Charles H. Warne		x
ERIE	Emil J. Meckstroth	x	x
HOLMES	Adam J. Earney	x	x
HURON	William R. Graham	x	x
LORAIN	Charles G. Adams	x	x
	Harold E. McDonald		x
	Henry E. Kleinhenz	x	
	James T. Stephens	x	x
MEDINA	Richard W. Avery	x	x
RICHLAND	Robert W. Jones	x	x
	Harold F. Mills	x	x
WAYNE	Albert Burney Huff		x
	Robert E. Reiheld	x	
	OFFICERS		
President	P. John Robechek	x	x
President-Elect	William R. Schultz	x	x
Past President	Richard L. Fulton	x	x
Secretary-Treasurer	James L. Henry	x	x
	COUNCILORS		
First District	Paul N. Ivins	x	x
Second	James G. Tye	x	x
Third	Dwight L. Becker	x	x
Fourth	George N. Bates	x	x
Fifth	David Fishman	x	x
Sixth	Maurice F. Lieber	x	x
Seventh	Sanford Press	x	x
Eighth	William M. Wells	x	x
Ninth	Oscar W. Clarke	x	x
Tenth	James C. McLarnan	x	x
Eleventh	Robert G. Thomas	x	x
	Total	159	162

The President's Address

By P. John Robechek, M.D., President
Ohio State Medical Association

Dr. Hoffman, Members of the House of Delegates, Honored Guests, Ladies and Gentlemen:

THIS MEETING of the House of Delegates represents the beginning of four days of determination of future policies for the Ohio State Medical Association, by you, its paramount governing body.

Since the last meeting of this House, The Council—which, according to the Constitution and Bylaws of the Ohio State Medical Association, acts on behalf of the House of Delegates and the members within the framework of policies enunciated and adopted by the House—has carried out a number of approaches to difficult problems.

Some problems were difficult by reason of their innate nature and future possibilities. Some



were difficult by reason of previous actions of this House of Delegates not now consonant with the time in which we exist, and some were made difficult by actions of members of the Association, not necessarily a part of this House but not to the exclusion of some members of this House.

A few points should be made and clarified before the reference committees consider the resolutions about to come before them.

Medical Advances Institute was formed by The Council to receive monies, bequests and grants, to establish educational programs, to transfer, when possible, certain OSMA activities to MAI as a means of relieving pressures for further dues increases. It is our hope that much, if not all of our educational and meeting expenditures can be transferred to MAI and these vital functions financed by sources other than by dues. Therefore, the Medical Advances Institute was formed. It is irresponsible to demand dissolution of Medical Advances Institute in the full knowledge that the costs of dissolution, followed by necessary costs of formation of **another** corporation for the purpose I have mentioned, would represent a waste of funds with no benefit toward the accomplishment of this purpose.

For these reasons, it is **my** opinion, sustained by The Council of this Association, that resolutions with regard to dissolution of Medical Advances Institute are moot and constitute fiscal irresponsibility.

On request of the Ohio State Medical Association, House Resolution Number 7182 was introduced by Congressmen Devine and Betts of Ohio. Congressman Devine—as conservative as the **most** conservative member of this House of Delegates—recognized that the establishment of Professional Standards Review Organizations under the terms of the Bennett Amendment of the 92nd Congress precluded physicians from being the majority of any group or organization with which the Secretary of Health, Education and Welfare could contract for professional standards review in each state.

Please bear in mind that a house resolution bears the same relationship to the law finally enacted by Congress that a resolution in this House bears to the final action by this House. It may be accepted, substituted, rejected, modified or may be incorporated, along with other resolutions, into the law which is finally enacted.

It is essential to remember that once a law is passed, there is little opportunity to modify it; witness the futile efforts by various committees—which included extremely well intentioned and influential members of our profession—to modify the law, or the impudent regulations issued by the Social Security Administration, **after** the passage of P.L. 89-97, the Medicare Act. Organized medicine was harshly criticized by members of our own profession and by our friends for not having introduced alternative legislation **soon** enough to

Presented Before the House of Delegates, Ohio State Medical Association, During the 1972 OSMA Annual Meeting in Cincinnati, May 8, 1972.

have provided Congress with a true alternative to Medicare. "Eldercare" was introduced so late that it had little or no consideration and all efforts to modify either the Medicare statute or regulations were ineffective.

Many members of our profession stated that organized medicine had "let them down," some resigned from the American Medical Association and more were openly critical of that Association and all of organized medicine.

The alternative to the repetition of such an episode is the introduction, in time to be considered, of legislation which is more consistent with the view that professional standards **shall** be determined by the medical profession and professional standards review **shall** be performed by the medical profession. Recognizing this, The council cooperated with Congressman Devine to provide the verbiage of H.R. 7182.

We considered and consider other action to be inimical to the interests and well-being of patients and the medical profession, as well as to individual members of the profession.

Testimony was presented before the House Ways and Means Committee and discussions were held with a member of the Senate Finance Committee Staff by representatives of the Ohio State Medical Association.

Before you condemn us for H.R. 7182, let me quote the powerful and respected Wilbur Mills, chairman of the House Committee on Ways and Means, upon hearing OSMA's testimony on H.R. 7182. Reminding you that this is one of the most powerful men in America—if not the most powerful—I quote Chairman Mills:

"Before yielding to Mr. Collier, let me suggest, Dr. Henry, it would be a great service to each and every member of Congress if they would take the opportunity to sit with a peer committee, looking over their (the committee members') shoulders and listening to their discussion of some of the fees that are charged by the doctors that are deemed to be excessive by the peer committee."

After informing his fellow members of the Ways and Means Committee of his experience in doing just that with the Arkansas Medical Society last summer, and expressing how deeply he was impressed by what he heard and saw, Mr. Mills added,

"I don't know how many of these cases escape the notice of the computer or the individual who brings it to the attention of the peer committee, but there were tremendous savings in the fees that day that were being charged. Frankly, I felt sorry for some of those doctors."

And Mr. Brotzman, a committee member from Colorado, said, "I just want to tell you, Dr. Henry, and say to my colleague, Congressman Devine, how valuable your testimony is because it becomes readily apparent to me that, if there is anything we must be wary of on this committee, it is that we come out with legislation, if that particular plan detracts from the quality of medicine, then we have actually done the people of this country a great disservice instead of trying to help them. This is something we really have to look at and test all the way."

Withdrawal of H.R. 7182 is no longer an option of the Ohio State Medical Association since it is now the property of Congress, and OSMA resolutions to withdraw H.R. 7182 are, therefore, also moot and irresponsible.

As a corollary to the introduction of H.R. 7182, it was the unanimous opinion of Council—including myself—that, **if** such legislation became law, the Ohio State Medical Association should provide a mechanism for its implementation. It is certain that professional standards review organizations will be mandated by federal law (either in the form of the now changed Bennett Amendment, **or** the American Hospital Association plan, **or** the Kennedy Plan, **or** the Administration's plan), and that medical associations or their agencies, such as a health care foundation, will be precluded from being named as the professional standards review organization. Therefore, it was and is the unanimous opinion of Council that, in the best interests of our profession and our patients, Medical Advances Institute **could and must** qualify as the organization under which professional standards review may operate in Ohio. It was for this reason that the statement of purpose of Medical Advances Institute was changed, in April, 1971—a matter which has received much comment from certain sources. It was the unanimous opinion of The Council—again including myself—then and now, that this was entirely appropriate and could provide physicians with the opportunity for final determination in any dispute which arose with regard to the care of a patient by a physician.

These are the **facts**, ladies and gentlemen; another **fact** is that there **will** be professional standards set, and cases **will** be reviewed by comparison with these standards. In most hospitals and county societies, there **has** been review since the end of World War II. Medicare and Medicaid mandated **all** participating hospitals to have review of the utilization of beds and facilities, which we, The Council, equate with quality and quantity of care.

It becomes apparent, then, that PSRO, [Professional Standards Review Organization] as envisioned in H.R. 7182, is the most logical step in review mechanisms. At no time has The Council considered claims review to be a part of PSRO except in disputed cases, which—it is our hope—

will continue to be the prerogative of county medical societies when **they act** in good faith. If they **fail** to act, the PSRO council and its committees (one for each recognized specialty) will act—much as the council fee review committee has acted in the absence of county society action—over as many years as I have been a member of The Council, and in fact since 1956.

Georgia, Utah, Colorado, Wyoming, New Mexico, and Illinois have applied for and received grants for review of Medicare and Medicaid cases because **they** offered to perform claims review.

The Council, through MAI, did **not** offer to provide initial claims review. Consequently, the MAI request for PSRO grants did not receive Federal funding to reimburse the members of the MAI Professional Standards Review Council or its specialty committees for their work. We, The Council, do not believe that **claims** review should be a part of the PSRO function in this state.

If it is the opinion of this House that—in spite of what I have told you—professional standards review **must not** be and shall not be, physician controlled, I would advise you to make certain that the Ohio State Medical Association does **not** form a professional standards review organization. That decision rests with this House. I would advise you further that, if you take such negative action, you must be prepared to accept nonmedical professional standards review by laymen. I advise you even further that you will be making certain that PSRO is **not** included in Medical Advances Institute, and that **this** inclusion or lack of same is the **sole** point to be discussed in the MAI—7182—PSRO combination.

I have given you a thorough resume of our actions and our reasons for our actions.

On numerous occasions, your officers and councilors have made similar presentations around the state.

Each step in our efforts was prominently published in *The Ohio State Medical Journal.*

Our activities have been reported in the *OSMAgram.*

We held an all-day orientation meeting for county society officers and specialty society officers, with a very substantial amount of time devoted to questions and discussions from the floor.

I would be derelict if I did not insert at this point a reference to a divisive, negative movement known as "The Council of Medical Staffs." This group in Ohio has provided no positive approach, and has contributed nothing but confusion and antagonism toward our efforts and our goals for medicine.

In view of all this, if it is the belief of this House of Delegates that the Officers and The Councilors of the Ohio State Medical Association have acted inappropriately . . . have acted for other than the good of the public and the medical profession . . . I would **urge** you . . . **nay, I demand of you** . . . that you here and now replace all officers and councilors.

What I have just demanded of this august body was done so only after considerable reflection . . . much soul-searching . . . and, above all, a **personal** reaffirmation of **my** convictions. It also has had recent reaffirmation by The Council.

This year has been one of deep frustration and concern. It has been one of observing labor, the American Public Health Association, the American Association of Medical Colleges, the American Hospital Association and national specialty societies offer—**even demand**—to become the "one national voice for all medicine."

They seek to supplant that strong and positive triangle of county medical society, state medical association and the American Medical Association. Any engineer will tell you that the triangle is the strongest, most efficient structural design known to man.

Further, I must solemnly and officially warn you that there is a serious movement at the national level to separate the American Medical Association from its confederation with the state associations and the county medical societies. Physicians in high places at the AMA and in other national medical groups are deliberately and aggressively attempting to set the stage for this amputation.

These persons advocate that proportionate representation be given in the AMA House of Delegates to the national specialty societies, the Association of American Medical Colleges and the Student American Medical Association. Their argument is that members of these groups have no voice in AMA affairs.

Their argument is thundering in its ignorance. First, the proponents of this scheme ignore the fact that the national specialty society, AAMC and SAMA members already have not one but two voices in the AMA House of Delegates. One voice is through their state delegations to the AMA and the second through their AMA specialty section delegates who have equal status and equal rights with the state delegates.

Most of these organizations are noted for not having a large majority of members that also hold membership in AMA.

These same persons argue that the state and county organizations are "dead as the dodo bird" and that we "serve no useful purpose."

Let me emphasize that I do not view this movement as a threat to the state and local organizations. I most definitely view it as a threat to the future of the AMA, and this makes it a threat to one national voice for grass roots medicine . . . the one voice that doesn't ask if a physician is

a pathologist, or surgeon, or obstetrician . . . but only that he is an ethical physician.

Your Council has instructed the OSMA delegation to introduce into the AMA House of Delegates a resolution in full and forceful opposition to this movement.

In addition, we will take any and all steps necessary and utilize all roads open to us to demolish this dangerous movement. I urge you and our colleagues back home to do the same.

But, returning to an immediate and serious situation within our own state, I beg that you consider and weigh carefully and objectively what I am about to say, and what I am about to say is this:

We, The Officers and Council, have spent much time and effort explaining, attempting to educate and persuade various groups of the interested and the uninformed, as well as the dissidents. The result is that we have had **no** time to proceed with our battle against the enemies **without,** because of our incessant battle with the enemies of this point of view **within.**

I put it to you in all sincerity, ladies and gentlemen, if it is your will, let us have the tempest in **our** teapot rather than elsewhere.

Let's quit being negative and start being positive. Let's quit listening to uninformed, distorted propaganda. Let's get our chins off our chest and hold our heads erect. After all, the public—our patients—think considerably more of us than you may realize.

We proved this here in Ohio recently by means of a pilot sampling of Ohio's citizens. The sampling was done by professionals in that field.

The poll showed that most of those polled indicated they held their personal physicians very close, in all respects, to their personal concepts of the ideal physician.

I am pleased that 97 percent of those polled had a family physician. What does that do to the sociologists, labor leaders and politicians who talk of "lack of access to health care"?

We plan to expand this poll, with some different questions, since it would appear that the medical profession in general is not so highly regarded as we, as a group, would like to be. Nevertheless, we are more highly regarded than the opposition likes to admit.

The poll showed that **most** of the public believes that both physicians and patients are victims of the "system" and that government—with its great experience in administration—was the most likely way to change the "system," so that neither the patient nor the physician would continue to be its victims.

The results of the extension of our study, when completed, will be made available to all members of the Ohio State Medical Association.

As a final point, I should like to emphasize to you that, at the same time this House of Delegates precluded Ohio Medical Indemnity, Inc., from entering into contracts with physicians or organizations attempting to experiment with different types of health care delivery, one portion of this state association was, in fact, forming a foundation for the delivery of health care. This foundation has, as I understand it, some 800 to 900 physicians who have indicated willingness to participate in such a delivery system.

Because of difficulties in financing mechanisms, with Ohio Medical Indemnity, Inc., as always, being responsive to the wishes of this Association, as represented by this House, the foundation has had dealings with a Blue Cross plan—with the ultimate goal of changing the enabling legislation in this State to permit Blue Cross to provide a prepayment plan for physician services.

Such legislation has been introduced in the Ohio General Assembly but has not yet been acted upon. Truly, this is an area where the left hand did not know, or care, what the right hand was doing. The Ohio State Medical Association Council firmly believes physicians' services should be paid for by Blue Shield plans **rather** than Blue Cross plans. We have objected to this legislative attempt to make benefits for **all** health services a part of Blue Cross.

These objections will be doomed if it is not made possible for Ohio Medical Indemnity, Inc., to participate in claim processing and fee payment on OMI's actuarially sound basis.

I realize that my address to you has been more of a review than a forecast, more of a diatribe against disunity than a plea for unity, more of an outline of the areas in which traditional roles in the delivery of health care—and particularly medical care—must be reexamined and, in all probability, be changed, rather than the provision of a set pattern for such change.

Change **always** will be with us and no amount of wishing for the old days and ways will stop the change. I would urge you to **guide** rather than blindly obstruct change, otherwise—if you remember my motto—the illegitimi **will** carborundum us.

With all its problems, this year has been an eye-opening experience for me. I wish to thank and pay tribute to all the members of Council who are—I assure you—among the most dedicated physicians I have ever known, and to thank and pay tribute to the chairmen and members of all committees of this Association, without whose dedication the work of this Association would never get completed. Last, but not least, I should especially like to thank and pay tribute to the excellent staff of the Ohio State Medical Associ-

ation—and I assure you there is none better **anywhere**—for their dedication and hard work to benefit all of us. Without them the multiple activities of this Association would never be accomplished.

My personal thanks, also, to this House which paid me the honor of election to the position of President of the Ohio State Medical Association, a role I have tried to fill to the very best of my ability.

The final evaluation of this year's activities on behalf of our profession may be some time in coming. I will say to you in closing, I hope it will be found to be of great value but I am prepared to accept the worst as well as the best views of my efforts.

Outstanding Exhibits Recognized at 1972 Annual Meeting

THE JUDGING COMMITTEE at the 1972 OSMA Annual Meeting gave special recognition to eight entries after reviewing some 49 Scientific and Health Education exhibits. It also recognized the Art Exhibit as an outstanding contribution to the Annual Meeting.

The entries were part of the overall exhibit on the floor of the Cincinnati Exposition Center, hub of activities for the Annual Meeting. In addition to the Scientific and Health Education displays, visitors had an opportunity to view some 74 Technical Exhibits sponsored by pharmaceutical manufacturers and other suppliers of products and services of interest to the medical profession.

Sponsors of the exhibits recognized were presented plaques to be displayed in their booths and kept as permanent mementos, with certificates indicating the various categories of awards authorized by planners of the Annual Meeting.

Following are brief summaries of the outstanding exhibits and awards presented. More detailed information will be published in coming issues of *The Journal.*

Gold Award in Original Investigation: The exhibit entitled "Management of Hypertensive Emergencies," sponsored by Donald G. Vidt, M.D., and Ray W. Gifford, Jr., M.D., of the Cleveland Clinic Foundation.

Gold Award in Teaching: The exhibit entitled "Know Your Eyes," a presentation on Anterior Segment Eye Diseases, sponsored by Ira A. Abrahamson, Sr., M.D., Ira A. Abrahamson, Jr., M.D., and Leonard Jacobson, M.D., of the Department of Ophthalmology, University of Cincinnati College of Medicine.

Silver Award in Original Investigation: The exhibit, "The Metabolic Abnormalities of Obesity," sponsored by Irving B. Perlstein, M.D., of the University of Louisville School of Medicine.

Silver Award in Teaching: The exhibit, "Indications for Total Hip Arthroplasty," sponsored by the following team of the Cleveland Clinic Foundation — Charles M. Evarts, M.D., H. Royer Collins, M.D., Kenneth E. DeHaven, M.D., Carl L. Nelson, M.D., and Alan H. Wilde, M.D.

Bronze Award in Original Investigation: The exhibit, "Biological Assay of a New, Nonfluorinated Topical Corticosteroid for Its Inhibition of Inflammation," sponsored by Marion Vujevich, M.D., University of Cincinnati Medical Center.

Bronze Award in Teaching: The exhibit, "Esophagus Replacement with Reversed Gastric Tube," sponsored by Henry J. Hemlich, M.D., of The Esophagus Center, The Jewish Hospital, Cincinnati; and William C. Gardner, M.D., of The Trover Clinic, Madisonville, Ky.

Honorable Mention went to the exhibit entitled, "Percutaneous Radio Frequency Coagulation of the Gasserian Ganglion for Trigeminal Neuralgia," sponsored by John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., Good Samaritan Hospital and Christ Hospital, Cincinnati.

A Special Award was presented to the Committee on Maternal Health for its exhibit on Obstetrical emergencies, including sickle cell disease as related to obstetrics. Anthony Ruppersberg, Jr., M.D., Columbus, is chairman of the OSMA Committee on Maternal Health, and headed the exhibit team.

A Special Award for Outstanding Service and Contribution to the OSMA Annual Meeting was presented to Harry Fox, M.D., Cincinnati, who headed the committee in charge of the Art Exhibit.

Inaugural Address

By William R. Schultz, M.D., Wooster
Incoming President, Ohio State Medical Association

YEARS AGO, a traveler in the Ozarks stumbled onto some strangely acting razorbacks. The hogs would dash off in one direction, turn suddenly and head off in another, stop, listen . . . and then be off again in still another direction.

While the traveler was puzzling over this peculiar behavior, a native of the region happened by. The stranger asked for an explanation. "Darndest thing I've ever seen," said the mountaineer. "For months, I've called those hogs to feed by pounding on a wooden trough with an axe handle. Then, a few days ago, a band of woodpeckers landed here and started pecking on every danged sycamore around. I tell you, mister, that's driving those hogs crazy."

Our nation has been beset by too many delusion-peddling woodpeckers calling attention to half-truths while pecking at supposed ills of medicine. The sounds of truth have been drowned out. Unless we—the physicians of this nation—grab the axe handle and pound out the message of truth to the people of this country—unless we give them an honest appraisal of facts, our patients—the people—are going to be misled into making some serious, irrevocable and far-reaching mistakes.

Therefore, I propose an "Up with Medicine" program where we all, armed with facts . . .

Speak up for medicine . . .
Act rather than react . . .
And let everyone know what medicine is . . .
Where we stand . . .
What we stand for . . .
What we have done . . .
And what we are doing.

We cannot do this in a defensive way. We must be positive. We must speak loudly and clearly . . . with resounding volume . . . to drown out the hollow staccato of the delusion-peddling woodpeckers.

Reports of the National Health Education Committee and the World Health Organizations have been twisted and distorted to support false conclusions. This, plus recognized lack of full medical care in certain areas, has caused medicine to become defensive. This propaganda barrage has created a climate of guilt-feeling, bad conscience and self-accusation among too many in the medical community. These feelings certainly are not in the tradition of truth that we were taught, that truth being to:

Take a careful history . . .
Do a thorough examination . . .
Assemble all the necessary laboratory data . . .

Then, and **only** then, without emotional bias, we are to make a diagnosis and prescribe the correct treatment.

Today, three of four deaths in America are caused by cardiovascular disease, cancer or accidents. We physicians well know—and advise our patients—that overeating . . . lack of exercise . . . cigarette smoking, drug abuse and alcohol are major causative agents in all these deaths. Our pleas for moderation and change in habits usually fall on deaf ears.

We well know that poverty, bad housing, lack of educational facilities and unemployment are basic forerunners of many diseases, but these are socio-economic problems that cannot be solved by doctors.

It is time to decide what medicine and doctors **can** do and what we **cannot** expect to do, if we are to avoid the frustrations that result from unduly high expectations on the part of the consumer, aggravated by impossible promises on the part of the political demagogue.

A deficient total health situation is not the fault of medicine any more than crime is the fault of the legal profession.

These are socioeconomic problems. No national health insurance scheme . . . no new so-called "health care delivery system" . . . will have any effect on the patterns of living or the disease causing habits of Americans. Why? Because you cannot legislate human nature.

It is long past time for us to use effectively our many talents . . . our broad training to make our own evaluation of the nation's health needs and living habits. We must identify that which we can do something about before we can act effectively.

As a first step, we must identify in the public's mind the difference between **medical care**

Remarks presented before the House of Delegates, Ohio State Medical Association, on the occasion of his installation as President of the Association, Cincinnati, May 11, 1972.

and health care. **Medical** care is what you and I, as physicians, personally provide our patients. **Health** care includes all other **nonmedical** health services, and facilities. In talking about health, we cannot overlook such health factors as food, shelter, nutrition, education, air pollution, water pollution, and many other elements that affect the individual's well-being.

Far too often, "health care" is wrongly identified as "medical care." This particularly is true when costs are discussed.

Further, we must never forget that the keystone of our strength is strict adherence to our Principles of Medical Ethics. The physician's ethical principles guide his deep concern for the individual patient. I am convinced that this concern helps place him "Number One" in the public's esteem of major American professions.

A Harris poll of October, 1971—just six months ago—proved that Americans hold—and I quote—"a great deal of confidence" in only one profession—medicine. Sixty-one percent of the people polled said they had a great deal of confidence in medicine and its leadership.

In the same poll . . . and in sharp contrast . . . only 23 percent expressed "a great deal of confidence" in the Supreme Court . . .

Organized religion, 27 percent . . .
Congress, 19 percent
The press, 18 percent
Organized labor, 14 percent . . . and
Advertising, 13 percent

Since the politician likes to call his one-half of one percent victory margin "a landslide and a mandate," what would you call a 61 percent vote of confidence?

Lest anyone think this fine rating means that we should rest on our laurels, let me emphasize that medicine's score in 1966 was 72 percent. Personally, I believe the 11 percent drop is the result of two things: (1) propaganda by unfriendly interests and (2) our own failure to speak out positively wherever and whenever we can grasp the opportunity.

A recent public opinion survey in Ohio showed that the consumer does not blame medicine in general or the individual physician for the increased cost of health care. Rather, the survey showed the consumer believes cost hikes are the result of health insurance programs, increased hospital costs, government programs and general inflation.

This same survey showed that the consumer equates his own physician with the profile that he draws for the ideal physician.

Let us not lose these respects and patient ties by silent capitulation to some new and untried system when patients—and doctors—become numbers . . . and numbers of patients become the "name of the game."



What I am suggesting as an "Up with Medicine" program is not a high-pressure sales and advertising campaign run by a public relations firm or even run by our own state headquarters. I am urging an individual program where . . . you . . . and you . . . and you . . . take the time to learn more about medicine . . . its public concerns . . . its positive programs . . . and then **tell the story** . . .in your own words . . . to your patients . . . to your friends . . . to groups . . . to individuals . . . to your Congressman . . . in your office . . . your church . . . your civic club . . . anyplace and anytime you can grasp the opportunity to speak out.

We have a heritage that gives us pride and confidence. We have an exciting future. We have a wealth of positive information available, some of which may be new to many of our members. OSMA will provide that information. All you have to do is ask for it.

Medicine's greatest enemy is the combination of apathy, defeatism and lack of knowledge among our members. The doctor who says, "No, I'm too busy," is missing an exciting challenge. And the stakes are too high for physicians to sink into oblivion while murmuring, "It's too late."

Lest anyone feel that I am advocating a return to the "good old horse-and-buggy days," please be assured that nothing is further from my mind. Medicine never stops. Medicine builds on the past as we constantly move into the future.

We can never be so in love with any system that we are unwilling to make **positive** changes.

Today, medicine faces the sharpest challenge of its ability to change without being overwhelmed . . . and without capitulating to every emotional health scheme confronting us. I believe our ability to accept this challenge is another reason we have earned so much public respect.

The entire history of our profession clearly demonstrates that we accept change . . . not for the sake of change . . . but change with reason, for progress and worthy goals.

I believe medicine's willingness to accept reasonable and sound proposals is being more and more recognized by the public in general, in the legislative halls, and in the news media. I just as firmly believe that more and more nonmedical interests are beginning to say to themselves, "Maybe we should have listened to the doctors in the first place."

Many proposals for change in medical treatment and delivery of health care are under consideration. These proposals are the subject of much discussion and much dissension in medicine's ranks.

Without compromising our position of strength, let us give a fair hearing to all proposed changes and then make the best decision for all concerned.

To move forward with an "Up with Medicine" program in order that we achieve positive change, we must have a rededication to medicine's Principles of Medical Ethics . . . the same dedication that has been responsible for medicine's eminent position in society.

We need a renewed spirit of active—not passive—cooperation by all segments of the medical community.

There can be no progress or positive change without reasonable discussion. So, let's work together, just as we have this week in this House of Delegates, and we will achieve our goal through the sound organizational structure of medicine.

Division of our ranks leaves us dangerously vulnerable to the exploitation of those who would destroy us. We must heal any malignant splintering of medicine into smaller and smaller—and weaker and weaker—groups . . . groups with special interests sometimes are not best either for our patients or for medicine.

I hope for a renewed spirit of cooperation and mutual effort that will continue in a relationship with all members of the health care field. Recently, Mr. Stephen Morris, president of the American Hospital Association, publicly stated that hospitals should grasp control . . . and be the sole leaders . . . in the health field. I mention this only to condemn it as a gross disservice to the entire health care industry.

Fortunately, we in Ohio have a close working relationship . . . without attempts at domination . . . with the Ohio Hospital Association, the Ohio Osteopathic Association of Physicians and Surgeons, the insurance industry and the Ohio Department of Public Health. The continued success of these joint efforts will be in direct proportion to the amount of time, thought, and activities we devote to them.

We all are in the same boat, so let's grab an oar and start rowing in the same direction. Drilling holes in the bottom of medicine's boat will not let out the waters of discontent.

There is so much to be achieved and so little time to do it. We can ill afford to dissipate our energies in small groups of regional or philosophical self-interests. To do so subverts too much energy from our principal goal . . . and, as always and forever, that goal is . . . the best medical and health care for all the people.



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Woman's Auxiliary Report...

Address Presented Before the OSMA House of Delegates at the 1972 Annual Meeting in Cincinnati

By Mrs. R. L. Wiessinger
1971-1972 President, Woman's Auxiliary to the OSMA

THE WOMAN'S AUXILIARY to the Ohio State Medical Association has been in the red this year. It was our endeavor to REDedicate ourselves to the purposes and aims of the auxiliary; to REDirect our sights to worthwhile goals and then to REDouble our efforts to make them all come true.

But I come before you this morning with a heavy heart. Let me make this perfectly clear that first of all it is because this is my last week as president of a dedicated group of women; secondly because it is impossible to report significant advances in our projects. We have lost another county this year leaving us just 51 — some of these are not too active. Our membership is down from last year.

Why all the apathy? Our state committee chairmen are specially chosen women who know their subjects well and are eager to help. I have visited 40 of the 51 counties and have found varying degrees of interest. In every instance where there is an auxiliary, good and friendly relations exist among the physicians' families.

We do not want to be looked upon as a do-gooder organization. We are your wives stepping in to help you do that which you haven't the time to do. We want to help you in the advancement of medicine, good public health, raising funds for loan scholarships and research, to assist in securing good medical legislation. Most important is our effort to act as a good liaison between the medical profession and the general public.



Outside of the very short visit of your representative to the auxiliary house of delegates, this presentation by the auxiliary president is the only instance of direct communication. Dr. Hoffman, President-Elect of the AMA, asked for better physician-patient relationship. I am asking for more and better physician and auxiliary relationship. You need us and we need you to want us.

Thank you.

The Ohio State Medical Association Presents

To

FREDERICK T. MERCHANT, DOCTOR OF MEDICINE

THIS 1972 CITATION

For

Distinguished Service to the Medical Profession

A NATIVE OF MARION, Ohio in General Surgery practice there since 1946, Frederick T. Merchant, M.D., has amassed an amazing number of awards for distinguished service to medicine and to his community.



A Phi Beta Kappa graduate of Ohio Wesleyan University, he completed his medical schooling at Johns Hopkins School of Medicine, followed by a year of surgical-urological training there, a year of training in pathology at Royal Victoria Hospital, Montreal, Canada, two years of surgical training at Case Western Reserve University Hospitals, Cleveland, and two years as resident surgeon at Royal Victoria Hospital, at the same time teaching surgery as a member of the McGill University Faculty of Medicine.

A diplomate of the American Board of Surgery since 1946, Dr. Merchant has held office, and received fellowships and other honors in more than a dozen professional organizations, more than 24 community and fraternal organizations.

As Past President and as a member of the State Medical Board of Ohio since 1957, Dr. Merchant was named several years ago as a representative to the Federation of State Medical Boards.

He is also one of five members of the Federation nominated to serve on the National Board of Medical Examiners. The purpose of the National Board is to prepare and administer qualifying examinations for the practice of Medicine.

But more directly, this Distinguished Service Citation is awarded Dr. Merchant for his outstanding leadership, in the Field of Medical Licensing Examinations, especially his contributions both state and nationally, in the development of the FLEX examination programs; and further his Meritorious Service as President of the Federation of State Medical Boards of the United States, Inc., 1970-71.

Therefore, members of the 1972 OSMA House of Delegates, it is with great pleasure that I have the honor of presenting this Ohio State Medical Association Distinguished Service Citation to an outstanding physician for having protected the art and science of medicine with his many contributions and his loyalty to his profession.

Conferred in the House of Delegates,
Ohio State Medical Association,
May 8, 1972, at Cincinnati, Ohio

P J Robechek MD

P. John Robechek, M.D., President

To

CHARLES AUSTIN DOAN, DOCTOR OF MEDICINE

A Grateful Profession Hereby Confers

The Ohio State Medical Association

DISTINGUISHED SERVICE AWARD

MORE THAN 120 original papers in the field of medical research!

Active membership in more than 30 professional medical organizations and other health groups;

Holder of more than 40 responsible positions in important scientific organizations, ranging from committee chairman to president, and including the chairmanship of the Ohio State Medical Association Committee on Scientific Work from 1942 to 1946;

National and international consultant;

Recipient of some 20 distinguished service awards;

Service in two world wars.

These statistics do not describe the collective accomplishments of a County Medical Society. This fantastic record describes one man—Charles Austin Doan, Doctor of Medicine.

His marvelous and amazing voyages in the world of medicine have taken him from his native Nelsonville, Ohio to Hiram College, to the University of Cincinnati, to Johns Hopkins and Harvard Medical Schools, to the Rockefeller Institute and then, in 1930, to The Ohio State University College of Medicine as professor of medicine and director, Department of Medical and Surgical Research.

In 1936, he became chairman of the Department of Medicine, physician-in-chief of Starling Loving University and St. Francis Hospital, and Director of Research.

In 1944, he became dean of the College of Medicine and director of the University Health Center, maintaining his capacities as professor of medicine and director of medical research.

In his 17 years as dean, as the College of Medicine enjoyed exemplary intellectual and physical growth, Dr. Doan continued to engage in meaningful, productive research, despite the heavy administrative responsibilities of a deanship and as health center director. During that period, his research led him to produce nearly 80 scientific papers which have been published in all parts of the world.

His name became synonymous with hematology.

Medicine is significantly closer today to a cure for leukemia because of his unremitting investigations.

Upon his retirement as dean in 1961, he continued until 1965 as director of the Division of Hematology, Department of Medicine.



In 1963, the University Board of Trustees established the Charles Austin Doan "Chair of Medicine," and the University awarded him an honorary Doctor of Science Degree in 1964.

But one of his highest honors came in 1960 when Dr. Doan became one of only a handful of American physicians to receive the American Medical Association Distinguished Service Award.

Despite his unending hours in the laboratory, Dr. Doan not only continued to carry a heavy patient load, but treated his patients with expertise, concern and compassion.

And so, members of the House of Delegates, in presenting this Ohio State Medical Association Award for Distinguished Service, we honor a physician for all times, a physician whose loyalty to the art of medicine is as unswerving as his dedication to the science of medicine.

Conferred in the House of Delegates,
Ohio State Medical Association,
May 8, 1972, at Cincinnati, Ohio

P. John Robechek, M.D., President

Sports Medicine Institute Scheduled for August 2-3

An outstanding program is set August 2 and 3 for Ohio physicians interested in sports medicine. Scene of the Fifth Postgraduate Institute for Physicians on Sports Medicine will be the Center for Tomorrow, 2400 Olentangy River Road, Columbus.

The two-day session is cosponsored by OSMA, the Ohio High School Athletic Association, and the Ohio State University College of Medicine.

Highlighting the program will be talks on "Insurance Aspects of High School Athletics" by Harold A. Meyer, Ph.D., Commissioner, Ohio High School Athletic Association; "Relationship of Coach and Team Physician" by James F. Mason, M.D., Columbus; "Football — 1972" by W. W. "Woody" Hayes, head football coach at The Ohio State University; "Special Teenage Medical Problems" by H. Spencer Turner, M.D., Columbus, and a special workshop at the OSU athletic facility featuring basic taping techniques, equipment, care of the eye, dental protection and prevention of heat illness.

A special feature for physicians in attendance will be a night of harness racing at Scioto Downs.

Physicians who have not received the official registration form and program mailed by the OSU Center for Continuing Medical Education may obtain a copy by contacting the Secretary, Joint Advisory Committee on Sports Medicine, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

The registration fee for the Institute is $30.00 per physician. The fee for the optional Scioto Downs activity is $8.00 per physician. The latter includes cocktails and a roast beef dinner.

Dr. Glenn Paisley was presented this year's Distinguished Service Award by the Loudonville Jaycees. He was cited for his participation in numerous community projects as well as his devotion to the practice of medicine.

Doctor
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ntraindications: Diabetes mellitus at can be regulated by diet alone; venile diabetes mellitus that is complicated and well regulated on sulin; acute complications of abetes mellitus (metabolic acidosis, ma, infection, gangrene); during immediately after surgery where sulin is indispensable; severe patic disease; renal disease with emia; cardiovascular collapse hock); after disease states sociated with hypoglycemia.

Warnings: Use during pregnancy is to be avoided.
Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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For complete details, including dosage, please see full prescribing information.

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Proceedings of The Council

Meeting of May 11, 1972

THE COUNCIL MET at 4 p.m. on Thursday, May 11, 1972 at Stouffer's Inn, Cincinnati, during the 1972 Annual Meeting of the Association. All members of the Council were present, including the four newly elected Councilors. Also present were Messrs. Page, Edgar, Gillen, Campbell, Clinger, Rader, Moore and Mrs. Wisse of the headquarters office staff.

New Councilors Introduced

Dr. Schultz called the meeting to order and introduced the newly elected Councilors, as follows: Dr. Stephen P. Hogg, Cincinnati, First District; Dr. John C. Smithson, Findlay, Third District; Dr. Robert E. Rinderknecht, Dover, Seventh District; and Dr. Thomas W. Morgan, Gallipolis, Ninth District.

Committee Appointments Approved

President Schultz presented to the Council his appointments to the special committees for 1972-1973. (See this issue of *The Ohio State Medical Journal* for the personnel of these committees, Pages 735-737.) By official action, the appointments to the special committees **were approved** by the Council.

Auditing and Appropriations

The Council **approved** the leasing of a Model IV, Magnetic Tape Selectric Typewriter, without the unattended operation feature, for a period of one year.

Advertising in Yearbook

With regard to a request for advertising in the 1972 *Caducean* yearbook to be published by the Ohio State University College of Medicine, it was the expression of the Council that the Association not be financially involved in this advertising, but instead support university chapters of the Student American Medical Association.

Medical Advances Institute

The Council voted to contribute the sum of $5,000.00 from the income of the sale of real estate located at Fourth and State Streets, Columbus, to the Medical Advances Institute.

Vote of Appreciation

The Council voted its appreciation to each and every member of the staff for his or her work during the 1972 Annual Meeting; and voted to commend Dr. Robert E. Zipf, Dayton, chairman of the Committee on Scientific Work, for an outstanding meeting this year.

The Council then adjourned.

ATTEST: Hart F. Page
Executive Director

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Annual Meeting Attendance

A Tabulation of This Year's Attendance with Comparison of Previous Years' Figures

MEMBERS OF THE Ohio State Medical Association from 81 counties attended the 1972 Annual Meeting in Cincinnati, indicating an excellent distribution of members who attended. In all, 1,118 OSMA members were present. In addition, 204 guest physicians were present, and 37 medical students. In other words, a total of 1,359 physicians and future physicians attended. The total attendance was 3,029, a figure which is broken down as follows: OSMA members, 1,118; guest physicians, 204; medical students, 37; Woman's Auxiliary, nurses, technicians, dentists, and miscellaneous guests, 1,172; scientific, health education, and technical exhibitors, 498.

Following are tabulated figures on Annual Meeting attendance.

1972 Annual Meeting Registration by Counties

With OSMA Membership Data

County	MEMBERSHIP Dec. 31, 1971	MEMBERSHIP May 4, 1972	Ann. Mtg. Registration
Adams	12	10	2
Allen	142	133	24
Ashland	27	26	3
Ashtabula	58	54	3
Athens	42	38	3
Auglaize	17	14	2
Belmont	59	59	2
Brown	17	17	3
Butler	204	201	39
Carroll	9	9	1
Champaign	15	13	1
Clark	139	129	18
Clermont	19	18	6
Clinton	21	20	6
Columbiana	73	69	2
Coshocton	19	19	2
Crawford	39	40	4
Cuyahoga	2269	2074	99
Darke	24	22	2
Defiance	29	28	3
Delaware	28	27	5
Erie	61	59	4
Fairfield	53	50	9
Fayette	14	14	1
Franklin	968	851	127
Fulton	16	16	2
Gallia	35	34	6
Geauga	30	30	4
Greene	55	53	7
Guernsey	23	22	4
Hamilton	1322	1253	324
Hancock	41	44	7
Hardin	25	27	4
Harrison	9	9	1
Henry	13	13	2
Highland	19	15	2
Hocking	9	9	1
Holmes	10	9	2
Huron	31	31	6
Jackson	13	12	3
Jefferson	74	73	6
Knox	35	31	4
Lake	121	120	6
Lawrence	23	22	6
Licking	71	73	10
Logan	17	15	3
Lorain	216	212	18
Lucas	625	579	35
Madison	16	17	8
Mahoning	351	332	13
Marion	67	69	7
Medina	60	57	5
Meigs	5	4	1
Mercer	19	19	4
Miami	62	61	11
Monroe	2	2	–
Montgomery	624	620	68
Morgan	4	4	–
Morrow	7	7	5
Muskingum	76	78	14
Noble	2	2	–
Ottawa	21	22	2
Paulding	8	6	1
Perry	8	8	1
Pickaway	19	19	3
Pike	12	11	–
Portage	58	58	3
Preble	6	6	1
Putnam	11	10	4
Richland	123	119	13
Ross	40	40	12
Sandusky	44	42	3
Scioto	67	61	6
Seneca	42	37	4
Shelby	21	18	2
Stark	340	338	27
Summit	591	577	25
Trumbull	142	140	7
Tuscarawas	51	52	4
Union	17	17	–
Van Wert	20	17	4
Vinton	1	–	–
Warren	15	14	5
Washington	31	33	9
Wayne	65	65	5
Williams	20	2	2
Wood	40	42	4
Wyandot	11	10	–
Honorary	4	4	1
TOTAL	10,314	9,736	1118

OSMA Annual Meeting Registration — 1919 to 1972

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.: Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			411	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465
1969	Columbus	1344	219	208	1780	518	4069
1970	Columbus	1160	189	224	1355	477	3405
1971	Columbus	1049	159	182	1116	451	2957
1972	Cincinnati	1118	204	37	1172	498	3029

Proper Techniques Important in Political Campaign

IN A POLITICAL CAMPAIGN, some information has to be regarded as "trade secrets" and not revealed in public statements. For example, OMPAC does not publicize that it is giving financial assistance to the campaign of this candidate or that candidate. To do so would only play into the hands of the opposition, stimulating the opposition to the need for a stronger campaign and more financial help from its supporters. After an election, reports on campaign contributions are filed with state or local election officials as required by law.

★ ★ ★ ★ ★

Interviewing candidates for public office to obtain biographical data and to get an expression of the candidates' views on social, economic and health questions is the function and responsibility of the county or state medical society. Ohio has excellent machinery for this. Making it work is the important point. Is your county medical society working at this?

★ ★ ★ ★ ★

It is the responsibility of the local medical society to dispense information on the qualifications of candidates to its membership. It is legal and ethical for this to be done. The local society has to determine how best to get this data to the membership, i.e., by word of mouth, or through bulletins and magazine articles. If given facts about candidates and accurate quotations from interviews with them, medical society members should have no difficulty in deciding which deserves support at the polls. Are you getting pertinent information on candidates from your medical society sources?

"Regardless of who wins the White House, resentment building up across the U.S. against profligate government . . . local state and national . . . may inspire Congress to ponder cost of any health care scheme considered and that's something they have failed to do in the past," opines *Medical News Report.*

So what? It means those with brains, integrity, and courage will have to be elected to the next or subsequent Congresses when health care schemes will be on the agenda.

OMPAC can play a direct part in this. To do so, however, it must have the widespread and enthusiastic support of members of the medical profession.

Have you made your 1972 contribution to OMPAC? Incidentally, OMPAC contributions (membership) are on an annual basis . . . no carry-overs.

★ ★ ★ ★ ★

Says a *Saturday Evening Post* editorial: "Lacking as it does any automatic or internal mechanism to correct its course, government, as it grows ever larger and more embracing, urgently needs the pressures that can be imposed only by an informed and active citizenry to keep it from creating and perpetuating one absurdity after another. It is more convenient to talk rather than to act. But if we really want government to be responsive, we must use all available means to let lawmakers know what we would like done, undone, or not done." — *Ohio Medical Political Action Committee.*

Annual Meeting Pictorial Review



Dr. Vincent LaMaida, Delegate from Cuyahoga County, and Dr. James Henry, OSMA Secretary-Treasurer, discuss a point before the start of proceedings.



Dr. Charles A. Hoffman, of Huntington, Incoming President of the American Medical Association, was a guest at the Annual Meeting, and is shown here with the OSMA President-Elect, Dr. Oscar Clarke.



Dr. Richard Meiling, chairman of the Ohio delegation to the AMA, speaks from the floor of the House.



Past President Richard L. Fulton takes the podium before the House of Delegates to present a gift to Dr. and Mrs. P. John Robechek, and to officially recognize the Outgoing President's service to the Association and the cooperative efforts of the Association's First Lady.



A Health Education exhibit that drew considerable interest was the one entitled, "We Can Keep Americans Health by M.D.'s Mobile Units." Dr. E. Z. Schmidt, left, has his practice centered in Mt. Vernon, but takes medical practice to neighboring communities by means of the mobile unit shown in the background. He is assisted by Mrs. Schmidt and son Don.

Annual Meeting Pictorial Review



Art lovers are numerous according to the attention drawn by the Art Exhibit. Here Mrs. Oscar Clarke stands beside one of her paintings, a second place winner in the judging.



One of the well-attended scientific sessions of the Annual Meeting was this one on coronary artery disease.



Dr. Theodore Fox, of Chicago, points to the screen as he discusses knee injuries as part of the Sports Medicine program. The program was sponsored by the OSMA Section on Sports Medicine.

Annual Meeting

Pictorial Review



One of the first duties and privileges of Incoming President William Schultz was to decorate Outgoing President P. John Robechek with the Past President's button.



The House of Delegates voted Honorary Membership in the Ohio State Medical Association to Charles H. Coghlan, chief executive officer of Ohio Medical Indemnity from its inception in 1945 until his retirement this year, for "services of unusual value to medicine." Shown here seated in the audience, Mr. and Mrs. Coghlan were escorted to the rostrum where he was presented the Honorary Membership and she was given a bouquet of roses.



Plaques presented in appreciation for their services to the Association are held here by four members retiring from The Council. From left are Dr. Sanford Press, Seventh District Councilor; Dr. George J. Schroer, Second District Councilor (1967-1971); Dr. Paul N. Ivins, First District Councilor; and Dr. Richard L. Fulton, who has served the last year on The Council as the Immediate Past President.

Annual Meeting Pictorial Review

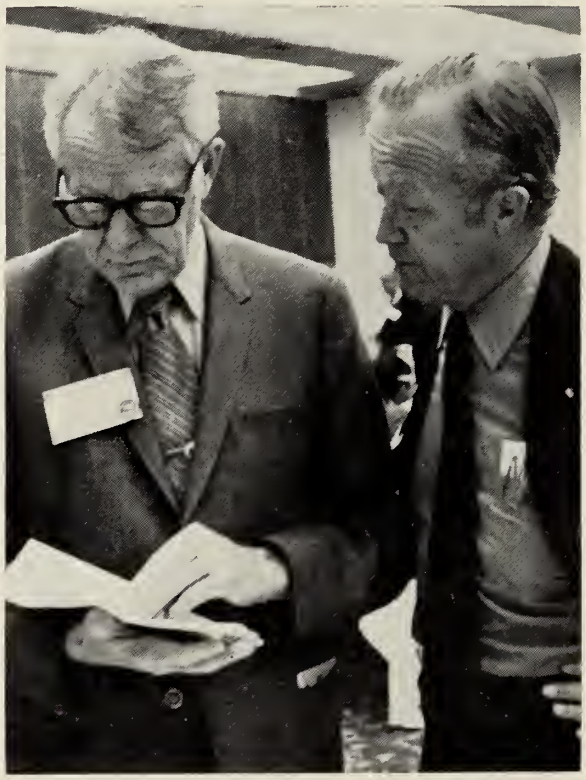




One of the best attended functions during the Annual Meeting was the luncheon sponsored by the Ohio Medical Political Action Committee (OMPAC). Here the audience of more than 400 persons gives undivided attention to the featured speaker, Robert D. Novak, Washington columnist and political analyst, shown at the left.



Two of the persons given certificates of appreciation before the House of Delegates are Dr. Glidden L. Brooks, for his service as former president of the Committee on Education, and Dr. Philip Hardymon, for his service as an Ohio delegate to the AMA. Dr. Brooks was further honored with a special award for his services to Ohio medicine as former president of the Medical College of Ohio at Toledo. He is now associated with the Lamuel Shattuck Hospital in Boston.



Dr. John Budd, Cleveland, member of the AMA Board of Trustees, and Dr. Robert N. Smith, Toledo, AMA Delegate, discuss a point of interest.

Annual Meeting Pictorial Review



The "Riverboat Odyssey" proved to be a popular social function for the Annual Meeting. Close to 600 members and guests boarded the craft and enjoyed a leisurely cruise on the Ohio River. A buffet dinner was enjoyed and a gay time was had by all.



Serious business, this thing of getting the Incoming President installed! Members of the William Schultz family are shown as they waited in the rear of the House of Delegates meeting room — Mrs. Helen Schultz, daughter-in-law Royana, and son, William Schultz, Jr.

Annual Meeting Pictorial Review

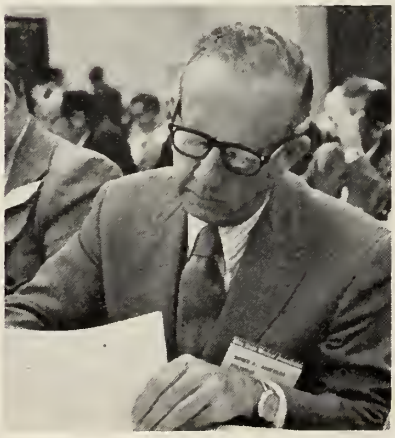






Here are two examples of Reference Committees of the House of Delegates. In the top photo, some of the members of the committee are seen hearing testimony. In the bottom picture, a discussion is heard from the floor of the committee room.







Chairmen of the four Resolutions Committees presented reports of their respective committees before the House of Delegates. They are Dr. Jasper Hedges (above left), Resolutions Committee No. 3; Dr. William Trowbridge (lower left), Committee No. 2; Dr. Homer Anderson (center), Committee No. 4; and Dr. Robert Clark (right), Committee No. 1.

Annual Meeting Pictorial Review



More than $50,000, Ohio's share in the AMA Education and Research Foundation funds, was distributed by Dr. Philip B. Hardymon, Ohio chairman, during House of Delegates proceedings. With checks in hand are four representatives of Ohio medical schools; from left, Dr. Clifford G. Grulee, dean of the University of Cincinnati College of Medicine; Dr. John A. Prior, dean of the OSU College of Medicine; Dr. Howard Madigan, associate dean, Medical College of Ohio at Toledo; and Dr. David Fishman, representing the Case Western Reserve University School of Medicine.



A number of visiting dignitaries were present for the Annual Meeting, among them Dr. Harry S. Weeks, Jr., President of the West Virginia State Medical Association, shown here extending greetings to the House of Delegates.



Dr. Hilaire J. Gaudreault, holds the Certificate of Humanitarian Services presented to him before the House of Delegates for his overseas tour under the AMA-sponsored Volunteer Physicians for Vietnam program.

Annual Meeting Pictorial Review



1971-1972 President Robechek displays a plaque while Mrs. Robechek holds a gift, both tokens of appreciation for a job well done. They were presented before the House of Delegates.



The traditional banquet honoring Past Presidents of the Association was held on Tuesday evening of the Annual Meeting Week. Past Presidents shown in the photo are, seated from left: Dr. Henry A. Crawford (1965-1966), Dr. Edwin H. Artman (1960-1961), Dr. P. John Robechek (1971-1972), Dr. Horatio T. Pease (1963-1964), Dr. Merrill D. Prugh (1954-1955), Dr. Robert S. Martin (1957-1958), and Dr. Harve M. Clodfelter (1952-1953).

Standing, from left, are Dr. Richard L. Fulton (1970-1971), Mr. Charles S. Nelson, former Executive Secretary, Dr. Carl A. Lincke (1949-1950), Dr. George W. Petznick (1961-1962), Dr. Theodore L. Light (1968-1969), Dr. Robert N. Smith (1969-1970), Dr. Robert E. Tschantz (1964-1965), and Dr. Charles L. Hudson (1955-1956) also AMA President (1966-1967).

Present at the meeting, but not in the picture were Dr. Richard L. Meiling (1956-1957), Dr. Frank H. Mayfield (1959-1960), and Dr. Robert E. Howard (1967-1968).



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though not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observations of clinical improvement.[1,3]

mposition: VASODĪLAN tablets, isoxsuprine HCl, 10 mg. and 20 mg. **Indications:** In cerebral vascular disorders for relief of symptoms due to vas-ar insufficiency associated with various conditions such as arteriosclerosis and hypertension. In peripheral vascular disorders for relief of symp-ıs such as intermittent claudication, coldness, numbness, pain and cramping of the extremities—in the management of arteriosclerosis obliterans, betic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite drome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Dosage and Administration:** In peripheral and cerebral vascular dis-ers—10 to 20 mg. three or four times daily. **Contraindications and Cautions:** There are no known contraindications to oral use when administered recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. **Adverse Reactions:** On rare occasions, l administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. casional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose. **Supplied:** Tablets, 10 mg.—bottles 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose. **References:** (1) Clarkson, I. S., and LePere, M.: Angiology *11*:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (4) Whittier, J. R.: Angiology *15*:82-87 b.) 1964.

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July

Fourth Annual Ohio State Urologic Outing—Subject, "Urologic Infections"; at Avon Inn, Warren, July 31-August 2; contact Chester C. Winter, M.D., Room N—809, University Hospital, Columbus 43210.

August

Fifth Postgraduate Institute for Physicians on Sports Medicine — Sponsored by OSMA, Ohio High School Athletic Association, and the OSU College of Medicine, August 2-3 at the Center for Tomorrow, 2400 Olentangy River Road, Columbus. Contact Center for Continuing Medical Education at Ohio State; registration fee, $30.

Third Annual Short Course on Laser Safety —Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, at the University, August 7-11; tuition, $325. Contact course director, Mr. R. James Rockwell, Jr., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229.

Annual Scientific Assembly, Ohio Academy of Family Physicians—Sheraton-Columbus Hotel, downtown Columbus, August 8-10.

October

Pediatric Postgraduate Conference, Ohio State University College of Medicine, October 4-5.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Group Psychotherapy, Ohio State University, October 6 through December 22 (26 hours).

Chronic Otitis Media in Children, Ohio State University College of Medicine, October 7.

Annual Cancer Symposium sponsored by the American Cancer Society, at Scot's Inn Motel, Columbus, October 11, 9:00 a.m. to 4:00 p.m. Contact, American Cancer Society, Ohio Division, 1367 East Sixth Street, Cleveland 44114.

Diabetes Seminar, Ohio State University College of Medicine, October 25.

Current Therapy III — Infectious Diseases — Third Annual Postgraduate Medical Seminar sponsored by the Scioto County Medical Society; Thursday, October 26, at the American Legion Hall, 705 Court Street, Portsmouth.

Psychotherapy of Adolescents, Ohio State University College of Medicine, October 27-28.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported alter Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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Woman's Auxiliary Highlights

Report on the 1972 Annual Meeting Woman's Auxiliary to the OSMA, Cincinnati

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

"STOP - FUN - INFORMATION." That was Ann Wiessinger's convention theme and it fittingly describes the thirty-second annual meeting of the Woman's Auxiliary to the Ohio State Medical Association held in Cincinnati May 8, 9, 10 and 11 at the Terrace Hilton Hotel. The "STOP" had its emphasis in the review of things accomplished and the taking stock of things to come. The "FUN" focused on the many outstanding social activities and the camaraderie that generates a very special warmth and understanding among the doctors' wives from all over Ohio. The "INFORMATION" spotlighted specific avenues of help for the local county groups and their incoming officers. For the first time, the outgoing State Board got together with the incoming State Board.

It was a smooth, action-filled convention, thanks to the untiring efforts of Mrs. Russell L. Wiessinger, president; Mrs. Robert E. Krone and Mrs. Walter B. Wildman, II, convention chairmen; and those innumerable, hard-working committees of Hamilton County members. What's that about "many hands make light work?" I don't really think that those "many hands" of convention made **light** work, but I most certainly think that they made light of the work! And in the process of it all, they came up with a most successful meeting. I doubt that many realize the enormity of the job that must go into "producing" a convention. I know I didn't — until I experienced one of my own!

It was at the pre-convention Board meeting on Tuesday morning, May 9, that the outgoing and incoming officers and chairmen established liaison. I have remarked before that there is always a degree of nostalgia at a pre-convention Board meeting and this year was no exception. It's the end of a year of close associations. New ones will take their place, of course — but there is that lump-in-the-throat feeling for those who are leaving the Board.

At 2:30 Tuesday afternoon a mini-conference for the 1972-73 presidents and presidents-elect was held in the Skyline Ballroom. This session was a briefing for the new county officers to assist them in the planning of their programs for the coming year and to bring them up to date on the new national auxiliary format on committees.

First Business Meeting

The first official business session of the convention came to order Wednesday morning, May 10, with Mrs. Wiessinger, president, Allen county, presiding. There were 104 official delegates in attendance. The invocation was given by the Rev. George Sonneborn, of the Mt. Olive United Church of Christ in Dayton. Mrs. A. A. Dalton, Allen County, past president of the Woman's Auxiliary to the National Medical Association, led in the pledge of allegiance. Mrs. Karl F. Ritter, Allen County, past national and state president, led in the pledge of loyalty. Mrs. Charles S. Blase, president Hamilton County, sounded the address of welcome. The response was given by Mrs. Thomas Leech, president, Allen County, at which time she presented, on behalf of the Allen County auxiliary, the handsome new Ohio auxiliary banner. It is handmade and striking — the white background, the map of the State of Ohio outlined in red and blue lettering. The banner was made and presented to the state auxiliary by the Allen County women in honor of Mrs. Ritter and Mrs. Wiessinger. Dr. P. John Robechek, president OSMA, extended greetings and thanks to the auxiliary and introduced the OSMA President-Elect, Dr. William R. Schultz.

Mrs. John Dickie, Lucas County, past state president, introduced these out of state guests: Mrs. Floyd K. Anderson of Hollywood, California, national treasurer; Mrs. Howard Lilijestrand, Hawaii, a national director; Mrs. Ben Johnson, Alabama, national AMA-ERF chairman; Mrs. Philip Smith, president, Indiana; Mrs. W. W. Stodshell, president-elect, Indiana; Mrs. Charles Schoff, president, Michigan; Mrs. Ralph Bliasiole, president, Pennsylvania; Mrs. John Eves, president-elect, Pennsylvania; Mrs. Robert Hartman,

president-elect, Illinois; and two former Ohio members now living in Florida — Mrs. Harry Fry and Mrs. Beach Hazard. The latter two were affectionately dubbed "displaced persons" . . .

Mrs. Wiessinger presented her convention chairmen, Mrs. Krone and Mrs. Wildman, and thanked them for an outstanding job. Pertinent announcements were made by Mrs. Krone. The "early bird" prizes were drawn by Mrs. Ronald W. McLin, whose Montgomery County auxiliary donated the three lovely gifts drawn Wednesday morning.

President's Report

Our 1971-72 President travelled 12,000 miles, visited 40 county auxiliaries and attended six other state conventions! Quite an impressive record, to put it mildly. Her opening remarks emphasized that "Ohio was in the RED this auxiliary year. Members were urged to REDedicate themselves to the purposes and aims of auxiliary; to REDirect their goals by reviewing good programs and projects of former years and giving them a new twist; and to REDouble their efforts to make them all come true."

Mrs. Wiessinger discussed such specifics as 30 counties which offered Health Career loans and 51 counties which offered Health Career scholarships. There are 51 organized counties with a membership (as of convention) of 5100. AMA-ERF continues to be a number one effort, the president pointed out. Through the sales of Christmas cards, writing paper, umbrellas, books, as well as through memorials, every county contributes and "according to present reports we will be well over the $20,000 mark for this auxiliary year."

In discussing legislation activities, Mrs. Wiessinger said that "our state legislation chairman mailed monthly letters to county chairmen, is a member of the OMPAC Board, conducted an informative workshop during the state fall conferences and made numerous speaking engagements to extoll the benefits of proposed Medicredit Health Insurance legislation."

Other county activities reviewed by Mrs. Wiessinger included the report that a group of auxiliary members from one county "adopted" a ward in the state mental hospital. Another group has given 11 concerts yearly which are held in local nursing homes, mental hospitals and VA hospitals. "They think of this service as a pleasant form of therapy," the president commented. Drug abuse and VD prevention programs were given high priority this year by a majority of the local auxiliaries. The visual aids "Dial-A-Drug" and "VD Dial" were purchased by the State Board for district directors to show their local groups. As a direct result, many auxiliaries are purchasing these aids for distribution to schools, churches, etc.

The president's report listed some 24,000 pounds of pharmaceuticals sent to international health agencies from the local groups, along with 51 pounds of equipment including an EKG machine, microscope, supply carts, 400 blankets and "many other items too numerous to mention." Mrs. Wiessinger spoke of a brochure sent out by a local auxiliary to Welcome Wagon newcomers to answer questions and correct misunderstandings relating to medical care, and to provide an opportunity for the medical profession to communicate any attitudes or suggestions they deem advisable for better community understanding. Safety programs covered a wide range, said Mrs. Wiessinger, putting emphasis on the bicycle, the snowmobile, the lawn mower, industry, the pedestrian and even help for the stranded motorist.

Two of Ohio's larger cities — Cleveland and Cincinnati — were chosen to be represented at the national Big City Council held in Chicago, from which many problems were brought to light and out of which added impetus was given toward directing new programs for metropolitan areas. Another national meeting described by Mrs. Wiessinger had to do with that sponsored by the AMA in conjunction with the national auxiliary — a health education forum to which 75 health-oriented organizations were invited.

The closing remarks of Mrs. Wiessinger's annual report is deserving of repetition here: "One of the questions often asked is 'what do we get out of auxiliary?' Webster says auxiliary means conferring help or aid—assistant—supporting—serving to supplement to take the place of, as an auxiliary power station. The primary purpose of the Woman's Auxiliary is to help or aid the medical society. Truly we are their power station. Auxiliary is a **giving** organization; we give help, we give funds, we give our time, we give our talents. It is only a **getting** organization in the good feeling we get from a job well done." (For the auxiliary president's remarks before the OSMA House of Delegates, see page 699).

Nominative Slate

Mrs. Carl F. Goll, Jefferson County, immediate past president and chairman of the Nominating Committee, presented her committee's recommended 1972-73 slate of officers: President-Elect, Mrs. Karl Ulicny, Columbiana; First Vice-President, Mrs. Jack Weiland, Montgomery; Second Vice-President, Mrs. Howard Smith, Lucas; Third Vice-President, Mrs. S. J. Glueck, Clark; Corresponding Secretary, Mrs. T. A. Russell, Trumbull; Recording Secretary, Mrs. H. I. Humphrey,







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SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

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ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY.

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT.

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of less concern because of this factor)[1]; (2) since SYNTHROID contains only T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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T DOES SYNTHROID S' LESS THAN STHETIC DRUGS STAINING T_3?

mple. T_3 costs more to make tically than does T_4. So it is hnically necessary for a tic thyroid medication ning T_3 to cost more than ntaining T_4 alone. Synthetic nations cost patients nearly ore than SYNTHROID[3] se the T_3 costs more to start lso there is the additional se of formulating a tablet ning two active ingredients.

an Druggist BLUEBOOK, Merch, 1971.

KNOWLEDGE OF THE '70's CHALLENGES CUSTOMS CONCERNING DESICCATED THYROID DRUGS.

In the past, desiccated thyroid produced from animal glands was considered "good, and cheap." We now know that improved products are available and the price difference has narrowed to the point of being inconsequential. (SYNTHROID, for instance, costs patients about a penny a day more than brands of desiccated thyroid.)

What does this additional $3.65 a year buy the patient? Quite a bit in terms of quality, reliability and service.

SWITCHING PATIENTS TO SYNTHROID IS EASY.

Switching present patients to SYNTHROID (or starting new ones) is a simple matter. SYNTHROID is available in the widest range of dosage strengths of any thyroid drug. Seven scored, color-coded tablet strengths are available plus a lyophilized injectable form for emergency or postoperative uses.

RESPONSE, RELIABILITY, SERVICE—COMPARISON OF FIVE PARAMETERS

AMETERS	DESICCATED THYROID U.S.P.	SYNTHROID® (sodium levothyroxine)
RCE OF HORMONE	Animal glands (swine, sheep, cows). Hormone content of glands and ratio of T_3-T_4 varies by type of animal, season in which gland is harvested, and diet of animal.[1,2,3,4,5]	Synthetically derived pure crystalline hormone. Because no animal protein is present, no objectionable odor occurs upon aging.
ERAL ASSAY TECHNIQUE	"Its major disadvantage is inadequate standardization of hormonal content."[8]	Unlike desiccated thyroid U.S.P., thyroxine does not require biologic standardization to establish its potency.[2,6] Crystalline T_4 is used. Purity is verified by paper chromatography. Content of tablets is standardized by weight.
ICAL RESPONSE	"T_3 and T_4 ratio varies according to gland source. Fluctuations in response can occur. Potency can vary."[3]	"Sodium levothyroxine has been extensively used with satisfaction and is widely held to be superior to (desiccated) thyroid."[7] "There are well documented examples of patients who failed to respond satisfactorily to desiccated thyroid but subsequently responded to (sodium-l) thyroxine."[4]
DICTABILITY	Failure of thyroid U.S.P. treated patients to show clinical improvement and/or lack of correlation in clinical findings to thyroid function test results has been frequently discussed in the literature.[8,9,10,11,12,13,14,15,16] Regardless of which factor or factors accounts for this phenomenon the fact remains that discrepancies do occur.	Test results predictably elevated. ". . . oral potency of this material is attested to by a uniformly good clinical response corroborated by a prompt and sustained increase in the serum PBI levels."[16]

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See next pages for prescribing information.







PATIENTS CAN BE SUCCESSFULLY MAINTAINED ON A DRUG CONTAINING THYROXINE ALONE.

Thyroxine (T_4) is, as you know, the major circulating hormone produced by the thyroid gland. T_3 is also produced, in smaller amounts, and is active at the cellular level. For years it has been a working hypothesis among endocrinologists that T_4 is converted by the body to T_3. In 1970 this process, called "deiodination," was demonstrated by Braverman, Ingbar, and Sterling[2]. T_4 does convert to T_3, though the precise quantities are still being studied.

The conversion has been clinically demonstrated during the administration of T_4 to athyrotic patients. Their thyroid status is normalized on SYNTHROID alone, yet the presence of T_3 in these patients has been clearly shown.

CONSIDERATE LONG-TERM THERAPY FOR THE PATIENT.

Predictable patient response, of course, is more important than price. You do get complete clinical response with the single-entity synthetic, SYNTHROID. And, at a reasonable cost to the patient. In some short term situations, T_3 drugs can be useful but, in long term therapy, the smooth road provided by SYNTHROID may be the better route.

SYNTHROID, with its smooth road to complete thyroid replacement therapy, has been selected for more patients in the United States and Canada than any other brand of thyroid medication.

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AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF TH PATIENT DURING TH BEGINNING OF THERAPY WILL ALE THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occ are related to excessive dosag Caution should be exercised administering the drug to patie with cardiovascular disease. Pa the accompanying prescribing information for additional data write Flint Laboratories.

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0.05 mg.



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0.2 mg.

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APPROXIMATE DOSAGE EQUIVALENTS*

			Animal Gland		
CYTOMEL (Sodium liothyronine) Synthetic T_3	EUTHROID** (Liotrix) Synthetic T_3-T_4	THYROLAR*** (Liotrix) Synthetic T_3-T_4	Desiccated (Thyroid, USP) Cow, sheep or hog thyroid	PROLOID (thyroglobulin) Frozen hog thyroid	SYNTHROID (Sodium levothyroxine) Synthetic T_4
Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

N.A. = Not Available Commercially

*Equivalents shown are chemical, and do not take into consideration individual patient variables. Clinical effect is approximate and should be monitored when converting a patient to SYNTHROID. This is particularly important in patients previously on desiccated thyroid. In these patients, lower doses of SYNTHROID may produce the same metabolic effect.

**Euthroid (#1 tablet) contains 60 mcg. of T_4 and 15 mcg. of T_3.

***Thyrolar (#1 tablet) contains 50 mcg. of T_4 and 12.5 mcg. of T_3.

Synthroid®
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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

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Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

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Franklin; Treasurer, Mrs. Paul Hahn, Tuscarawas. Directors at large to serve two years: Mrs. Armin Melior, Scioto; Mrs. William Myers, Pickaway; Mrs. Daniel S. Wolff, Lucas. District directors: Second — Mrs. Kenneth Smith, Miami; Fourth — Mrs. M. S. Huber, Seneca; Sixth — Mrs. Karl Wieneke, Mahoning; Eighth — Mrs. Carl Frye, Licking; Tenth — Mrs. David Smith, Delaware.

There were no nominations from the floor. Mrs. Wiessinger moved that since there was only one nominee for each elective office that the vote be by voice and that the nominees as presented by the Nominating Committee be acclaimed the elected 1972-73 officers. Motion carried.

Mrs. Goll then presented the names for the 1972-73 Nominating Committee: four from the Board, two of whom are to be elected; ten from the general membership, five of whom are to be elected. As there were no nominations from the floor, Mrs. Wiessinger announced that the election for the 1972-73 Nominating Committee would be by ballot at the designated voting hours that afternoon.

The President then called for nominations for delegates and alternates to the convention of the Woman's Auxiliary to the American Medical Association to be held in San Francisco June 18-21. Twenty-two such names were placed in nomination. Instructions for voting were then detailed by Mrs. I. A. Nickerson, Licking, parliamentarian.

National Speaker

Mrs. Floyd K. Anderson, national auxiliary treasurer, was introduced by Mrs. Karl F. Ritter, past national president. (Mrs. Ritter is a member of the committee responsible for the publication of the national anniversary history, "The Right Side of the Caduceus").

"Auxiliary is many things", commented Mrs. Anderson. "Auxiliary is a continuing process. At the national level, we look **up** to that most important county level, where all the work is done." She went on to say that auxiliary is friendship; that auxiliary is restraint at times, leaving unsaid the wrong thing at the tempting moment; auxiliary is vision to which we must hold fast; auxiliary is a responsibility, a privilege and a challenge; auxiliary is concern for the future of medicine and our country.

Mrs. Anderson discussed many of the important services rendered state and county auxiliaries by the national organization. She quoted Dr. Charles Hudson, past AMA president, who in 1967 said: "If there were not an auxiliary, we would have to create one."

AMA-ERF Awards

Mrs. Karl Ulicny, Columbiana, AMA-ERF chairman, presented these awards: To Hamilton County for the largest contribution in the state (over six thousand dollars); to Ashtabula County for the largest increase over the preceding year; and to Butler County for the greatest per capita increase. Mrs. Ulicny announced that as of that moment at convention, Ohio had raised over $70,000 for AMA-ERF this auxiliary year. If that isn't something to crow about, I don't know what is!

Mrs. Ben Johnson, national AMA-ERF chairman, congratulated Ohio on its outstanding accomplishment and discussed what it means to raise money for medical education. She praised the Francois Greeting Card Company of Cincinnati for its highly cooperative efforts in the sale of Christmas cards for the benefit of AMA-ERF.

In Memoriam

An impressive Memorial Service was conducted by Mrs. Christopher Colombi, Cuyahoga County, past state president, assisted by Mrs. Thomas L. Manning at the piano, and by Mrs. Paul Chrenka and Mrs. F. M. Freimann for the lighting of the candles, four of which stood as sentinels around the centerpiece of white carnations. (They represented the northern, southern, eastern and western segments of Ohio) "It is fitting," said Mrs. Colombi, "to use carnations as our remembrance flowers—for the carnation means divine crown and the crown denotes honorary distinction. Its spicy fragrance was used long ago to 'preserve the body of men, both in mind and spirit.'" The memory of 40 auxiliary members from 16 counties was honored at this special service.

The first business meeting recessed at 11:05 a.m.

OMPAC Luncheon

Robert D. Novak, prominent Washington newspaper columnist, made a "return engagement" Wednesday noon for the OMPAC luncheon. Mr. Novak had so impressed his audience two years ago that it was felt he was a natural choice this year to discuss "Politics 1972." And discuss them he did—forthrightly, dynamically, seriously and often humorously. And always without any show of partisanship.

Idea Exchange

At 2:00 p.m. auxiliary members gathered in the Skyline Ballroom for the traditional idea exchange via the presentation of the county presidents' reports. Each of the 11 district directors

introduced the presidents in her area. As always, this is a high point of convention because a county president and president-elect hear about successful projects and programs that can often be translated into activities for their own group. I guess this session could well be dubbed "inspiration time."

Later, Wednesday afternoon, Dr. and Mrs. Wiessinger hosted a reception for Board members and county officers. It was a time for "getting to know you" and another opportunity to discuss projects and problems.

Second Business Meeting

The second business meeting was called to order by Mrs. Wiessinger, president, Thursday morning. But before the official opening of that meeting (I got a bit ahead of myself!) there was that 7:30 a.m. "Stop and Swap" breakfast and although the hour was mighty early, the room was crowded with those who had come to garner yet more ideas! This was eloquent testimony to the interest and dedication of our leaders all over the state. Five counties featured special displays: Cuyahoga, Bargain Boutique; Trumbull, Mobile Meals; Hamilton, A Look to the Future; Montgomery, Operation Venus; and Stark, Party Night. Seven other counties shared Monthly Program Ideas: Lake, Licking, Lorain, Miami, Muskingum, Scioto and Tuscarawas.

The breakfast featured a bit of delightful entertainment—Clark County's Singing "Doctors" (the female vocalists wore green operating room garb and stethoscopes dangled from their necks) They did a take-off on "A Feller Needs A Girl" with these opening lines: "A doctor needs a girl, a strange kind of girl—at the end of a weary day" . . . .

Following the breakfast session, the second business meeting got under way at 10:10 a.m. Early bird prizes were drawn by Mrs. Paul Woodward, Jr., whose Butler County auxiliary donated the attractive gifts. There were 105 delegates present. Mrs. Dickie again introduced the out of state guests who had been presented the day before, along with Mrs. Bruce Martin, president, West Virginia auxiliary, who just arrived that morning.

Mrs. Calvin Warner, finance chairman, read the 1972-73 budget as approved by the preconvention Board and moved its adoption. Motion carried. Mrs. William Myers, Pickaway, resolutions committee chairman, presented the Courtesy Resolutions in which deep appreciation was expressed to all who had helped to make this convention a success.

Mrs. Willis L. Damschroder, Sandusky, chairman, gave the report of the Election and Tellers Committee: Those elected to the 1972-73 Nominating Committee from the Board—Mrs. Russell Wiessinger, Allen; Mrs. Paul Hahn, Tuscarawas; those elected from the general membership—Mrs. Damschroder; Mrs. Reuben Gould, Cuyahoga; Mrs. John W. Elliott, Clark; Mrs. Henry Clapper, Stark; Mrs. Alfred Slivinski, Franklin. Mrs. Damschroder then announced the names of the 17 elected delegates to the convention of the Woman's Auxiliary to the American Medical Association in San Francisco.

Installation

It was an impressive and warm installation that was conducted by Mrs. Malachi W. Sloan, II, past state president. "This moment is the most precious out of all the years of auxiliary", she remarked. In investing the new officers with the rank, authority and responsibility of their respective offices, Mrs. Sloan presented each one with an attractive "rosette" that had been sent air mail by Mrs. Willard C. Scrivner of Illinois who will be going in as national president-elect. Each rosette was of a different color—purple, gold, blue, green, vari-colored, red—and each color had a special significance which Mrs. Sloan detailed. In presenting the purple rosette to the new president, Mrs. Louis A. Loria, Mrs. Sloan said: "Purple denotes leadership".

Mrs. Russell Wiessinger was presented the past president's pin by Mrs. Carl F. Goll, immediate past president, who expressed the auxiliary's deep appreciation for a job well done. Mrs. Wiessinger, in turn, presented the president's pin and gavel to Mrs. Louis A. Loria, and expressed good wishes, on behalf of the organization, for a most successful year. As Mrs. Wiessinger gave the pin to her successor, she remarked "this has been the happiest year of my life, except for the first year of my marriage".

Inaugural Address

Mrs. Loria announced as the theme for her year "Improving the **Quality of Life** through health education." The **Quality of Life,** she said, depends to a great extent on the effectiveness of education and we are specifically interested in the areas of personal health, family health, community health and world health. She first spoke of improving the Quality of Life in broad terms, and then she discussed the specifics:

1) Continuing to work for OMPAC and for legislation; 2) forming a Speakers' Bureau at the county level to speak on health education, proposed health care systems, and so on; 3) individual responsibility for preventive medicine through health education activities and 4) stressing the areas of nutrition and safety. "I am particularly interested in education which helps us attain physi-

cal well-being, emotional well-being and good environment", commented Mrs. Loria, "and education which helps individuals realize their capacities and lead into the future . . . . it has been said that a mind once stretched can never return to its once small capacity . . . . let us realize that people must have self-esteem, must think that they are worthwhile beings before they will receive information and use it for their betterment. Herein lies the key for motivating the lay people to be individually responsible for maintaining their health and preventing illness."

The new president quoted Dr. Effie Ellis of the American Medical Asociation, who says that there are four things we can do when confronted with a challenge: first—we can do nothing; second—we can act as an obstacle which means we may disagree; third—we can act truly as an individual; fourth—we can act as an individual in a collective way. "Which of these will you do?" asked Mrs. Loria of her auxiliary members.

She concluded her address with "A Prayer: Crocus-Minded" which in part observes that "Somebody has to stick his neck out, somebody who cares enough to think through—and work through—hard ground—because he believes and has something personal and emphatic to say about it." The first part of the prayer had referred to crocuses and their "knifing up through hard-frozen ground and snow, sticking their necks out, because they believe in spring—and have something personal and emphatic to say about it."

Crocus-minded? asked the prayer. "Could it be that there are things that need to be said, and you want me to say them?" Mrs. Loria added: "Could it be that there are things that need to be done? And you want me to do them?" It was a beautiful prayer, and one of the most meaningful I have ever heard. And I wasn't the only one who reacted that way!

At 11:30 a.m. Mrs. Wiessinger declared the Thirty-Second Annual Convention adjourned. Mrs. Loria and her incoming officers were honored at a reception given by the Trumbull County auxiliary.

Anniversary Luncheon

The Skyline Ballroom was the luncheon scene, and a most attractive one it was. Intriguing birdhouses made by the Hamilton County members centered the tables. It was the occasion for honoring the members of the OSMA Advisory Board and the past state presidents. The Advisory Board this 1971-72 year included: Dr. Paul N. Ivins. Dr. Maurice F. Lieber and Dr. Dwight L. Becker.

The luncheon highlight was the delightful entertainment provided by the Hamilton County Choral Group under the direction of Mrs. Charles Sherrick. And the commentary on "Broadway Hits Through History" so ably given by Mrs. John H. Sheblessy. Along with the commentary, of course, there were many haunting melodies. There were lively tunes that precipitated considerable foot-tapping under the table. . . . The Choral Group may not have been aware of it, but it had considerable help in some of the numbers from the past presidents' table!

Reflections

Much as I would like to do so, it just isn't possible to include in this story on the convention full details. Or to give adequate thanks to Ann Wiessinger. Or to tell about the "Gavel Club" dinner (the annual get-together of the past state presidents.) Yet I would be remiss if I failed to note the happy presence of Dr. Loria and Jean, the youngest Loria daughter (there are two others) who had flown in from Cornell. Their smiling faces reflected their pride.

Both Ann and Eileen received beautiful gifts from their respective counties. If anybody wanted to meet somebody (or other!) the favorite spot was the Ohio Room where county scrapbooks were on display and where coffee and sweet rolls were served each morning. This continental breakfast was made possible through the courtesy of Ohio Medical Indemnity, Inc., of Columbus, Medical Mutual of Cleveland, the William S. Merrell Company and E. R. Squibb & Sons.

The presence of our two "displaced members" —Frankie Fry and Mae Hazard—added a glow to convention. And Jane Sloan added a special note of liveliness in her dramatic effort to get a windfall of OMPAC memberships (what's that about your promise, Jane, in relation to a "Centerfold??) I have lost count of the number of memberships Jane received in relation to her goal, but I have a hunch she's going to have to make good on her promise! (Centerfold? Shades of Burt Reynolds??)

All facets of auxiliary activity provide fertile soil for close friendships and for loving service to the medical profession. The annual convention readies the soil for the miracle of accomplishment. I am reminded of a quotation of Thomas Carlyle: "Is a miracle any less a miracle because it happens every day?"

Obituaries

Robert E. Barney, M.D., Palo Alto, Calif.; University of Michigan Medical School, 1921; aged 75; died May 15; former member of OSMA; member, American Dermatological Association; diplomate, American Board of Dermatology; practicing physician in Cleveland from 1925 to 1949. Dr. W. Raymond Barney, of Cleveland, is a brother.

Earl R. Berry, M.D., Napa, Calif.; Northwestern University Medical School, 1960; aged 38; died April 17; associated with the Ohio University Health Service and Southeastern Ohio Mental Health Center, Athens, until about November, 1971; served in the U. S. Air Force from 1964 to 1966.

Myron Edward Crawford, M.D., Rocky River and Lakewood; St. Louis University School of Medicine, 1936; aged 63; died May 10; member of OSMA and AMA; Fellow, American College of Obstetricians and Gynecologists; practitioner in the Lakewood vicinity for most of his professional career; veteran of World War II.

James Quinn Dorgan, M.D., Columbus; Ohio State University College of Medicine, 1926; aged 74; died May 30; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in Columbus for 45 years. Two sons are physicians, Dr. James Quinn Dorgan, Jr., who was associated with his father in practice, and Dr. John D. Dorgan, who recently completed his internship.

Erwin Richard Hexter, Jr., M.D., Westlake and Bay Village; University of Louisville School of Medicine, 1934; aged 65; died May 7; member of OSMA, AMA, American Academy of Family Physicians, and American Society of Abdominal Surgeons; practitioner of long standing in the western areas of Greater Cleveland.

Herbert Franklin Kesinger, M.D., Sandusky; Ohio State University College of Medicine, 1938; aged 59; died May 9; member of OSMA, AMA, and the American Academy of Ophthalmology and Otolaryngology; diplomate, American Board of Ophthalmology; past president of the Ohio



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Ophthalmological Society; practitioner in Sandusky since 1948; veteran of World War II.

Lewis Victor Kogut, M.D., Chagrin Falls; Loyola University Stritch School of Medicine, 1936; aged 64; died February 4; member of OSMA, AMA, and American Academy of Ophthalmology and Otolaryngology; practitioner for many years in the Greater Cleveland area.

James Wellington Norris, M.D., Columbus; Ohio State University College of Medicine, 1935; aged 64; died May 14; former member of OSMA; practitioner in Columbus, specializing in obstetrics and gynecology, before his retirement.

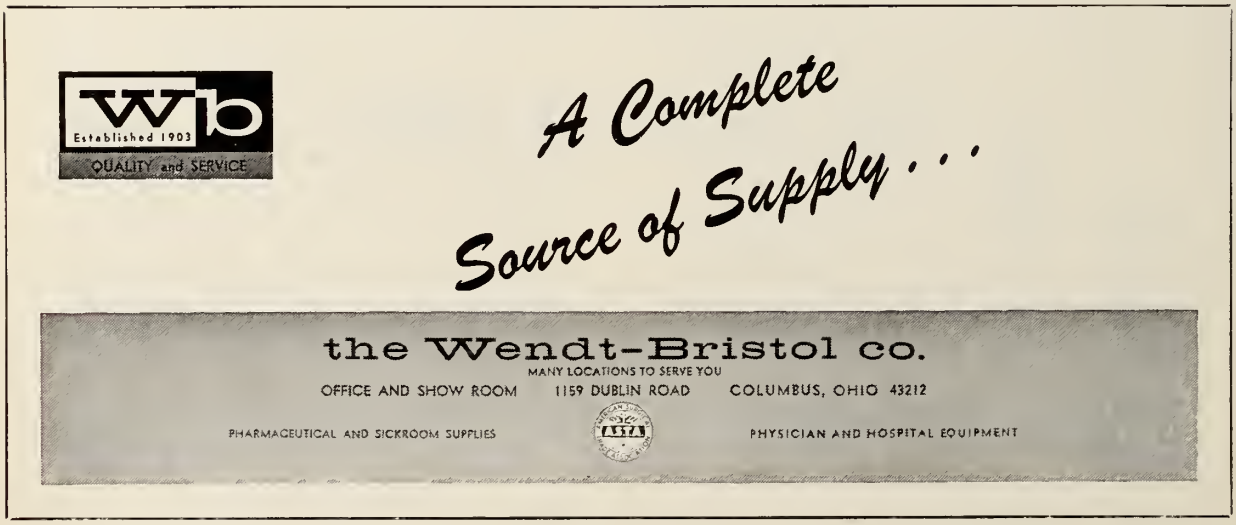
Ernest Thomas Pearson, M.D., West Milton; Ohio State University College of Medicine, 1925; aged 72; died May 8; member of OSMA and AMA; native of the area and practitioner in the West Milton vicinity for some 44 years; retired about a year ago.

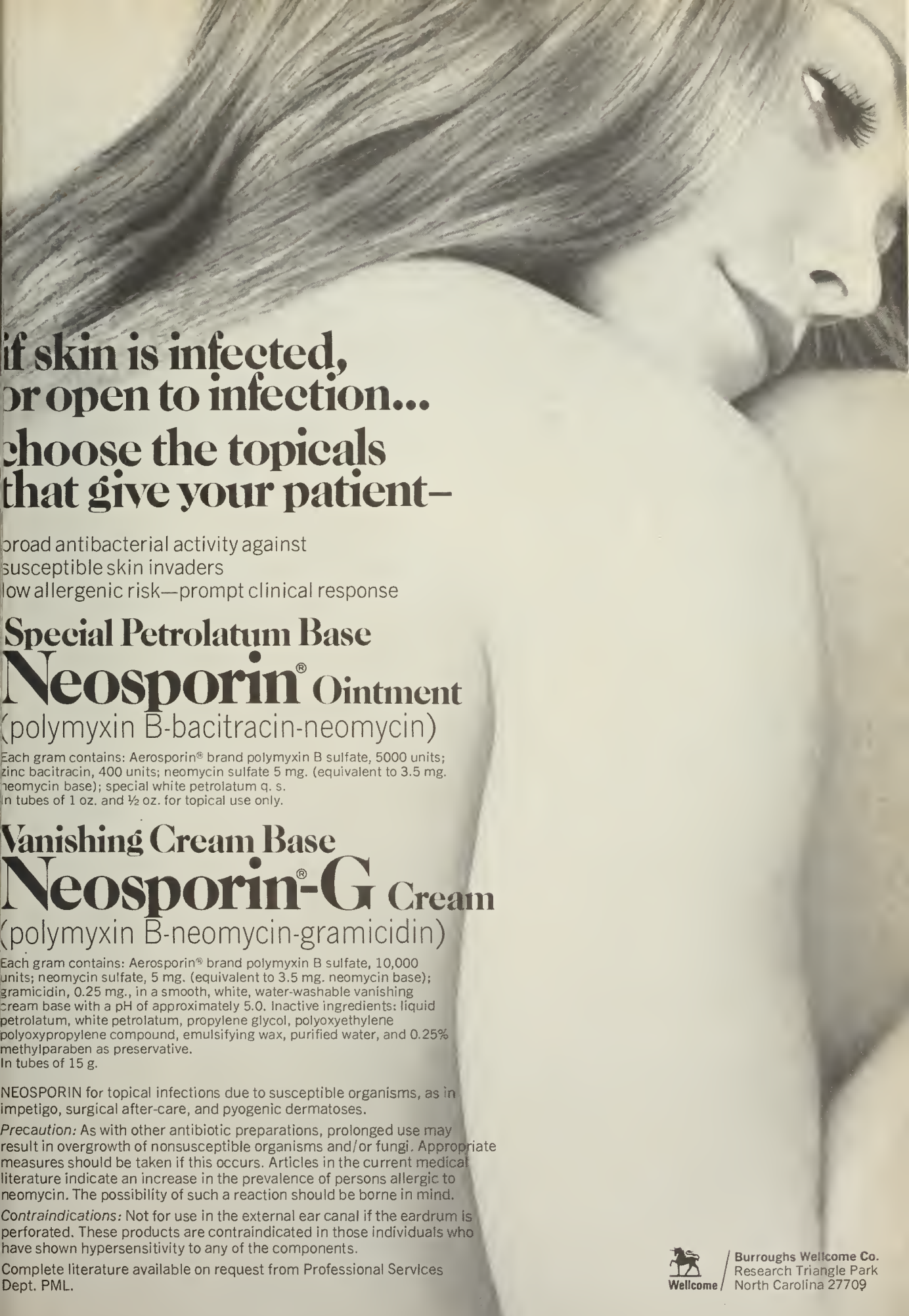
John H. Schulte, M.D., Columbus; University of Cincinnati College of Medicine, 1948; aged 48; died April 18; member of OSMA, AMA, Industrial Medical Association, American Academy of Occupational Medicine; Fellow, American College of Preventive Medicine; diplomate, American Board of Preventive Medicine; former career medical officer in the U. S. Navy with the rank of captain; for several years on the faculty at Ohio State University in the Department of Preventive Medicine.

Gerald A. Stack, M.D., Downey, Calif.; University of Cincinnati College of Medicine, 1946; aged 56; died May 9; practitioner in Lorain before he moved to California some 22 years ago.

William Lewis Wead, M.D., Washington, C. H.; Ohio State University College of Medicine, 1933; aged 61; died May 1 in Florida; member of OSMA, AMA, American Society of Anesthesiologists; and International Anesthesia Research Society; practitioner for some 26 years in Sabina before moving in 1960 to Washington C. H. where he continued to practice.

James David Witzler, M.D., Waterville; University of Michigan Medical School, 1959; aged 41; died April 30; practitioner in the Waterville and Toledo area since 1960; former deputy coroner for Lucas County; served in the U. S. Navy during the mid-1950s.





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Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

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1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

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a e been reported, some of these in
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e cillin.

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e ertheless, Lincocin should be used
c iously in patients with asthma or
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atients with impaired renal function,
e recommended dose of Lincocin
u ld be reduced to 25—30% of
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k ney function. Its safety in
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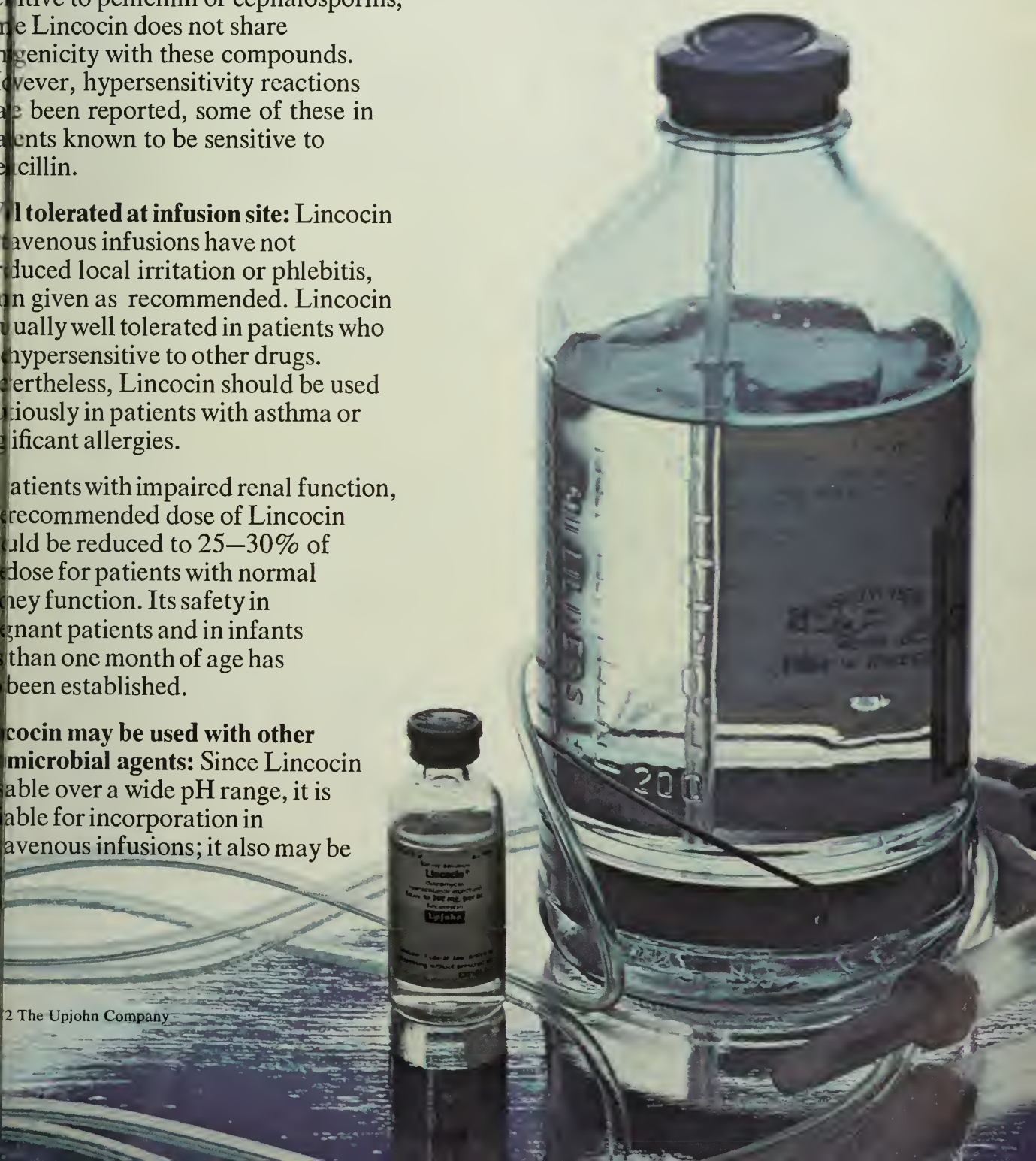
cocin may be used with other
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a able over a wide pH range, it is
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a avenous infusions; it also may be
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Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatr *Skin and mucous membranes*—Skin ra urticaria, vaginitis, and rare instances c foliative and vesiculobullous dermatitis been reported. *Liver*—Although no dire lationship to liver dysfunction is establi jaundice and abnormal liver function (particularly serum transaminase) have observed in a few instances. *Cardiovas* —Instances of hypotension following p teral administration have been repo particularly after too rapid IV admin tion. Rare instances of cardiopulmonar rest have been reported after too rapi administration. If 4.0 grams or more ad istered IV, dilute in 500 ml of fluid administer no faster than 100 ml per *Special senses*—Tinnitus and vertigo been reported occasionally. *Local reac* —Excellent local tolerance demonstrat intramuscularly administered Linc (lincomycin hydrochloride). Reports of following injection have been infreq Intravenous administration of Lincoc 250 to 500 ml of 5% glucose in dis water or normal saline has produce local irritation or phlebitis.

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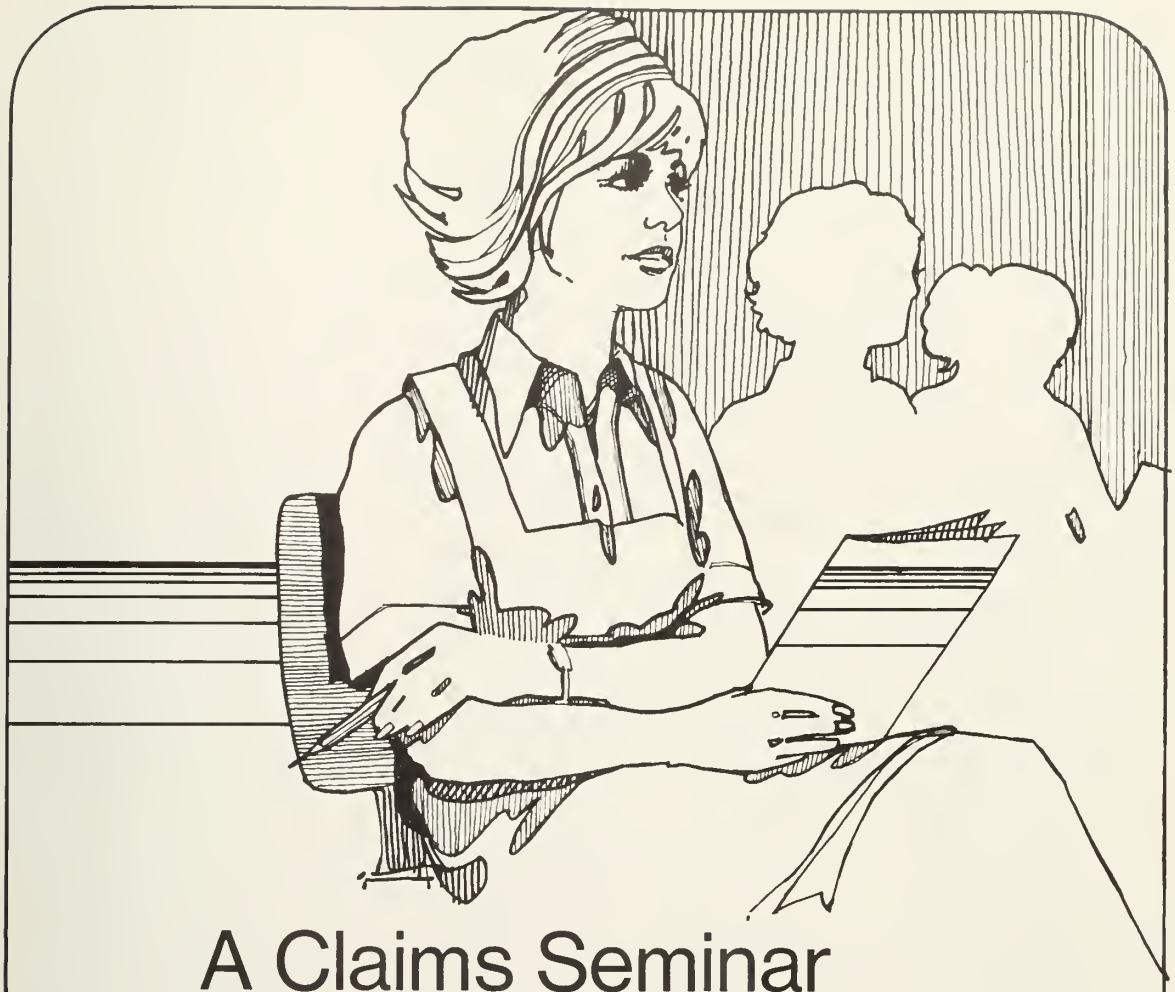
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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

ISPLAY
RIALS

A Symposium on Medical History

Page 769



DR. EDWARD TIFFIN
FIRST GOVERNOR OF OHIO

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Epilepsy Foundation Chapters Active in Ohio

The Epilepsy Foundation of America reported in its June issue of the *National Spokesman* that the epilepsy movement in Ohio is expanding in scope and services to the estimated 213,040 persons in the state who have epilepsy.

Chapters are active in Columbus, Cleveland, and Cincinnati. Other chapters are being developed in Toledo, Canton, Akron, Dayton, and Youngstown. It is anticipated that by this time next year the five new chapters will be active.

The Greater Cincinnati Council on Epilepsy has received word that its application for $28,120 from the Developmental Disabilities Services funds has been approved. The Cleveland chapter received $38,954 last year. The Epilepsy Association of Franklin County in Columbus has a grant application pending.

The Epilepsy Foundation of America has its headquarters at 1828 L Street, N.W., Washington, D.C. 20036.

Cincinnati to Sponsor Seminar in Southern France

Medi-Club, Inc. of the Cincinnati Academy of Medicine is inviting its members and members of their families to participate in a tour and medical seminar in conjunction with the Southern France Medical Association under the direction of Dr. Charles Bardon, October 1-9 in Juan Les Pins, a short distance from the Nice Airport.

Attendance certificates will be given to all the participants and some timely subjects are to be discussed such as: "The Influence of Government on Medical Care," "The Controlling of Fees by Government," "The Role of the Family Practitioner in French Medicine," "Dental Care in France," and "Malpractice in France — A. Insurance; B. Costs/Defense."

"French Night" will be held at the Medi-Club on Thursday, September 7, beginning at 8:00 p.m. at which color slides will be presented.

For details contact John E. Albers, M.D., Travel Chairman, at the Cincinnati Academy Headquarters, 320 Broadway, Cincinnati 45202.

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Relative Efficacy

When the Government Decides What Drugs Should Be Prescribed, Is the Patient Better Served?

IN THE FALL OF 1971, several officials of the Food and Drug Administration began stating that drug manufacturers should provide information on the comparative usefulness of their medications in the treatment of specific conditions. Such "relative efficacy" data they said should be made part of the prescribing information supplied to physicians in drug product labeling.

To persons familiar with the history of the Food, Drug, and Cosmetic Act, the statements from FDA were far from novel. Indeed, the matter had been thoroughly discussed a decade before, when Congress was in the process of enacting the 1962 Amendments to the Act.

At that time, Secretary of Health, Education, and Welfare, Abraham Ribicoff, stated unequivocally that those who had expressed concern that the new law might be used to permit the Federal Government to make relative efficacy judgments had "no basis for such apprehensions". The proposed amendments, he stressed, "would merely require a showing that the new drug described in the application is safe for use and is effective in use, under conditions prescribed, recommended or suggested, in the labeling thereof. This would not require a showing of relatively greater efficacy than that of other drugs. It would merely require that a drug claimed to be effective for a particular purpose had been demonstrated by sound scientific procedures to be effective for that purpose. In short, it must live up to the claims made for it."[1]

When asked specifically if FDA wanted the power to decide relative efficacy, Secretary Ribicoff answered, "We do not seek it. We do not want it. And my testimony indicated we do not intend to pass on it. . . We do not want to pass on relative efficacy. We do not want to say that drug A is better than drug B or B is greater than C. We are not looking for that at all, and we do not think it is necessary."

Colorado Senator John A. Carroll pursued the matter still further, noting: "you know, some of the doctors have testified that they themselves do not know that drugs operate differently on different people." Mr. Ribicoff agreed, "Absolutely correct. . . We would not and do not intend and do not want to pass on relative efficacy. This is no power we seek and no power we desire."[2]

It would be difficult to express a more clear-cut denial of any intention to act to determine relative efficacy than that of the former HEW Secretary.

Yet it appears that a change in the Department's stated position is intended by some at FDA, apparently on the unsupportable grounds that drug labeling, which does not indicate the product's relative position on a therapeutic scale, is not fully informative, or is somehow false or misleading.

In order to follow that reasoning, one must assume that a prescribing priority system can be clearly established, and, if so, that the Federal Government should be the judging agency.

And that is the crux of the matter.

The question of whether relative efficacy **should** be judged by the government is preceded by the question of whether it can be accurately determined. For some drugs, a consensus of expert opinion has been reached. In these cases, the less desirable drug has either vanished (bromides for anxiety, mercurials for diuresis), or has shrunk to prescribing levels justified by the advantages it retains (veratrum for hypertension, sulfonamides for infection). Results of this sort do not require government intervention. On the contrary, it may well be that attempts to impose consensus by fiat rather than by scientific and professional interaction would have had a counterproductive effect.

That leaves many areas of therapy and many groups of drugs for which a consensus has not been reached. Can the government line up, for example, all of the drugs in use against high blood pressure, and meaningfully arrange them in order of efficacy? If so, the physician's task could be simplified immensely.

But the answer to this question is **no.**

A number of controlled studies have failed to show any significant difference in efficacy between the major antihypertensive drugs.[3] Yet, while the experts in the field and the prescribing physicians may be at odds not one seems to claim

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This article was prepared and submitted to The Journal by the Pharmaceutical Manufacturers Association (representing manufacturers of prescription pharmaceuticals), C. Joseph Stetler, President.

that the major antihypertensive drugs now available are indistinguishable with respect to efficacy or usefulness.

While informed experts decline to make arbitrary judgments about the order in which particular drug products should be used, legislation is now pending (S. 2812, 92nd Congress) that would prevent the marketing of any drug not proven to be better than those already available. Had this bill been in effect when the first thiazide diuretics reached the market, it seems likely that only a handful would be available. Researchers, encouraged to proceed even if their discoveries were only modest, found more than a dozen such products, offering the physician a broad range of activity to meet his patient's needs. And, the availability of these alternatives has doubtless been a factor in the reduction—by about 15 percent at wholesale—in the price of the average diuretic.

It is thus impossible to justify the relative efficacy requirement from an economic point of view, let alone a medical one.

Still, some FDA employees are ready to decide such issues. According to the *Washington Post* of October 24, 1971, "some [FDA] scientists say that the diuretic market is saturated. 'We need another diuretic like a hole in the head' one FDA scientist said."

The question asks itself: Do the American people want FDA deciding when the last diuretic has been discovered, or instead do they wish to see further research leading to improved diuretics encouraged?

In this connection, it is noteworthy that early tests of a drug often fail to uncover some of its best advantages. For example:

- The early research on dimenhydrinate was directed toward its antihistaminic properties; only late in the program was another of its characteristics—its usefulness against motion sickness—noticed;

- The first research using the phenothiazines was in sedation; the drugs' cardinal value in psychoses came to clinicians' attention later;

- Again, the value of isoproterenol in shock, of mafenide acetate in burns, and of lidocaine in cardiac arrhythmia, were not recognized for years after their widespread use for other, less important medical indications.

Had FDA taken the shortsighted position then that one or two good drugs for each therapeutic need should suffice, the drugs just mentioned might never have been marketed; FDA could have said, in each case, that still another antihistamine, another sedative, one more cardiac stimulant, yet another topical antibacterial, and another local anesthetic—was not needed.

Your Opinion, Please, Doctor

The Journal's Publication Committee is presenting this paper on the relative efficacy issue in the belief that Ohio physicians are concerned about regulatory moves by the Food and Drug Administration in regard to prescription drugs.

We would call attention also to the series of "Opinion and Dialogue" messages being run in current issues of *The Journal* by the Pharmaceutical Manufacturers Association. This is a series of discussions by persons eminent both in medicine and in the pharmaceutical field, with an invitation to the reader to offer his comments.

Members of the Publication Committee would urge readers of *The Journal* to express their opinions on this timely and all-important issue.

Because FDA did not make such arguments when these drugs were before them for approval, hundreds of thousands of patients have benefited enormously, in many cases to the extent of recovering the chance to live.

Similarly, there is a difference of medical opinion on the value of antihistamines, corticosteroids and sympathomimetic agents against allergy, with no clearcut consensus on the issue. A lack of unanimity also exists with respect to the therapy of peptic ulcer, where anticholingergics and antacids are used, and in various musculoskeletal conditions, where some advocate muscle relaxants and others order only phenobarbital, much depends on the particular patient.

In such cases, FDA traditionally has followed the lawfully required and prudent course of letting the relative merits of the drug be found through experience, once the general quetsions of safety and efficacy have been answered. The National Academy of Sciences/National Research Council's 1969 Drug Efficacy Study commented on the point:

> "The final arbiter of the value of a drug is the consensus of the experience of critical physicians in its use in the practice of medicine over a period of years. Approval of a new drug for release to the market is only a license to seek this experience."

That process has been responsible for the large array of steroids of value in contraception, for example, and for the development of new drugs for the management of gout and diabetes. In each of these areas, seemingly trivial differences

in the drug not infrequently make major differences to patients—and make arbitrary relative efficacy judgments impossible.

Even in the case of the antibiotics, where it is often assumed that it is easy to match the medication against the disease, it is not uncommon to find authoritative disagreements as to the drugs of first choice (or second and third for that matter). For example, one well-known medical guide[4] suggests that the drug of first choice in the treatment of acute gonococcal infections is procaine penicillin G, and that a tetracycline or erythromycin may be used as alternatives; a second and equally respected book[5] mentions no alternatives; a third[6] lists erythromycin ahead of tetracycline, and adds a cephalosporin to the list for the physician to consider; still another book[7] does not list any of the alternates listed in references 4 and 6, but adds six separate penicillinase-resistant penicillins, and (any) sulfonamide. None of the referenced guides mentions spectinomycin, a relatively new (1971) antibiotic that has been the subject of numerous favorable reports.

Clearly, there is no unanimity as to the precise ranking of the alternates to penicillin G in treating gonococcal infections; indeed, there is no agreement as to what the alternatives are.

It must be borne in mind that the physician is not only dealing with a disease, which may follow a varied course, but also with an individual patient, whose reactions to the drugs prescribed may be crucial to the outcome of the therapy. Because the individual patient's reactions can make it dangerous to give him what for most patients is the "drug of choice," the physician must be permitted freedom to use his own judgment.

Recognizing the importance of allowing the doctors' judgment to prevail, Cornell University's Peter Dineen, M.D., in his chapter on antibacterial drugs in the 1970-71 *Drugs of Choice* wrote:

> "Clinical knowledge is often the method used in selecting a drug, and it may be the best. Properly applied it combines a knowledge of experimental and clinical evidence of the efficacy of various drugs with personal clinical experience. Once the infecting organism is identified, therefore, a reasonable selection of drugs can be made based on experience and knowledge."

Louis Weinstein, Ph.D., M.D., of Tufts, in his chapter on the chemotherapy of microbial diseases in the Goodman and Gilman text, put it another way:

> "Presentation of choices of specific agents for the treatment of various infections is always provocative of discussion and disagreement because such choices often represent the distillate of personal experiences that may not duplicate those of others. . . To complicate matters, sensitivity patterns of a number of microorganisms often vary with the hospital or clinic in which they are isolated. . . The material presented in this table represents the practice of the author based on his experience with the management of these infections. It is not intended to suggest that the indicated choices are necessarily those of other physicians or that the order is absolute. . ."

And, Dr. Louis Lasagna, head of the University of Rochester Medical School's department of pharmacology and toxicology, has observed:

> "Progress could be defined as discovering truths that are unrecognized or unaccepted by the experts. As someone who has been dubbed an expert by others, and who rather enjoys the privileges that go with that label, I am not suggesting that expertise has no utility in this world. But the experts can err—witness the thromboembolic hazards of the Pill, or the clinical reports (so long derided) and the antidepressant properties of phenothiazines, or the growing body of knowledge that USP standards (concocted by experts) are inadequate. (And, what more, the experts often disagree among themselves — if you doubt this, poll any group of experts on the antibiotics of choice to be used in treating septicemia of unknown origin.)" (*Clinical Pharmacology and Therapeutics* 11:3, p. 443).

If there is a difference of expert opinion and a need for flexibility in the selection of antibiotics, that need is doubly evident in the selection of many other modes of therapy, where the causative agent or factors may well be less clearly understood, and the characteristics that distinguish one useful drug from another may be considerably less discreet. In the treatment of psychotic disorders, for example, it is widely acknowledged that the relative value of one major tranquilizer as against the others cannot be determined in advance, even though these agents have been under careful and aggressive study for more than 20 years.

Again, the choice of digitalis preparations still presents a challenge, although physicians have studied the use of various forms of these cardiac drugs for about three millennia. Still, according to digitalis authorities Gordon K. Moe, Ph.D., M.D., and Alfred E. Farah, M.D. in Goodman & Gilman (p. 700), "What really matters is not so much the choice or purity of preparations, but the wisdom with which the drug is used by the physician."

Recent research in pharmacology indicates that there may well be a sound scientific foundation for recognizing the full importance of the use of skillful case-by-case judgment that cannot be performed by experts or authorities absent from the patient-doctor transaction.

The four main factors in a therapeutic relationship are: (1) Physician prescribes (2) drug against (3) disease of (4) the patient. The notion of relative efficacy assumes that for a given disease (factor 3), drugs can be ranked independent of physician (factor 1) and patient (factor 4). This assumption is false. Recent discoveries suggest that the individuality of the patient, and of the physician play very important roles in determining the effectiveness of drug treatment.

In one review[8] we read:

> "Although it has been recognized for many years that patient-environmental variation is important in determining drug effects, only recently has it been appreciated that genetic factors may play a large part in subtle drug-patient variation. Not all drug-patient variations can be ascribed to genetic factors, but the increasing use of metabolic blocking drugs and enzyme inducing drugs has heightened the clinical awareness of possible subtle pharmacogenic problems."

In the area of mental illness, at least, there are increasing suggestions that the importance and effectiveness of drug therapy vary markedly depending, in part, upon the therapist's experiences, values, and personality.[9]

Dr. Louis Lasagna discussed the value of relative efficacy information during a January, 1972 conference at the University of Rochester. "To be against information on relative efficacy," he said, "is to be against apple pie, mother love, and the American flag. It turns out, however, that relative efficacy is very difficult to assess. . . How nice it would be to have controlled trials data on all those drugs in patients who have for example, angina, coronary heart failure, hypertension, melancholia and asthma—but the mind boggles as you think about doing these trials."

Supposing, for example, that a new antithyroid drug were marketed, Dr. Lasagna posited that "You might say, 'Well, shouldn't the doctor know how this drug fits in, in terms of relative efficacy, relative toxicity, with other drugs, radioactivity, surgery—a few of the major modalities available for treating hyperthyroidism?' It would be nice again indeed; but again, the prospects of coming up with controlled trials comparing all of those simultaneously is pretty remote."

Moreover, there is a real question as to whether the cost of designing meaningful, definitive studies would be even remotely justified by the patient benefits to be expected. In most therapeutic classes, the number of distinct drug entities of value in treating a particular condition is small, frequently less than a dozen. Broadly speaking, the pharmacological effects of the group can usually be described, as is done in any of the standard texts of therapeutics. Using this information, and adding his own background and experience, the physician chooses one compound, basing his choice on the particular therapeutic (or economic) qualities it offers his patient.

Rather than expend limited clinical research resources testing one well-known drug against another, the prudent use of those resources clearly lies in the development of entirely new compounds.

Meanwhile, information on the relative place of marketed drugs, weighing their therapeutic indexes against alternate therapy, is being collected and published in the usual ways. Better data on the overall ratio of desired effects to unwanted ones, which characterizes a given group of compounds when used in a particular situation, assists the physician, not merely in choosing a given drug, but also in selecting from alternative classes of compounds of possible value to the patient.

The provision, by their peers, of information for physicians' guidance is, of course, a far different thing than the provision of even the same information by the federal government, whose "guidelines" more often than not carry the force of law. The question naturally arises: What does it mean when the government—as distinguished from a private body or expert—asserts that Drug A is the one of first choice in Condition A? What is the physician's legal position if, on the basis of his personal experience and educational background, he responsibly disagrees?

The question has been raised many times, and in various ways. Over the years FDA officials have challenged distinguished clinicians and practicing doctors who openly advocate usage of prescription drugs in conditions and at dosage levels not indicated in the FDA-approved labeling.

In 1967, for example, Dr. Walter Modell reported that FDA lawyers were claiming that "publishers, authors and editors who have written, approved and published drug dosages which deviate from those recommended by the FDA are liable for damages. . ." Objecting to this as regulation of medicine by fiat, "to which all doctors will have to turn like Holy Writ when they seek help on drugs," Dr. Modell called attention to the danger of letting FDA assume such power. "There must be free and unrestricted expression of opinion and publication of experience with drugs already officially described and delimited

in FDA stuffers," he said, "if progress is to be made in therapeutics and if egregious errors, one way or the other, by the FDA, are to be promptly published and rectified."

Moreover, he said, "in the case of every single drug, the determination of actual efficacy, proper dosage, and safe use requires substantial experience by the expert as well as by the general practitioner. It is held by many that it takes about five years before a definitive statement can be made about a new drug."

The issue was rejoined in 1970, when FDA Bureau of Drugs Director Henry Simmons, M.D., advised doctors that whenever they intended to prescribe a medication for use in a manner not approved in the official FDA labeling, they should first file a "Notice of Claimed Investigational Exemption for a New Drug" form.

AMA's Department of Drugs objected vigorously, fearing that "the FDA proposes to approve, forbid, monitor, collect, collate, evaluate, and disseminate results of all clinical experience with drugs in this country that is not consistent with package insert recommendations, regardless of the agency's statutory jurisdiction. . . We believe the FDA should devote full attention to meeting its statutory obligations, not attempt to expand its statutory grant by regulating the practice of medicine."

AMA stressed that "the physician should always remember a subtle but important distinction: The FDA has no legal authority to approve the uses of marketed drugs; it approves what a manufacturer may say about these uses in its labeling and advertising."[10] Earlier, AMA had published its belief that "the package insert is part of the labeling of a drug and not a legal restriction on the thoughtful and careful use of a drug by an informed physician."[11]

That "subtle but important distinction" has never been acknowledged by the FDA, however, and increasingly, in liability actions brought against physicians, failure to adhere to the labeling recommendations is being portrayed by medical malpractice lawyers as **ipso facto** evidence of wrongdoing. Recognizing this, the American Academy of Family Physicians, in an April 7, 1972 letter to FDA, said that relative efficacy judgments in government-approved labeling would carry the threat of "implied police power, if in no other way by the threat of such regulations being used as a 'club' in malpractice suits." The Academy, which represents 31,000 family physicians, urged that FDA abandon any plans to require relative efficacy statements.

One of the most astute students of the regulatory process in drugs worldwide is Sir Derrick Dunlop, the recently retired head of Britain's Medicine Commission, a sister agency to the FDA. Speaking at a symposium in Geneva in September 1971, Sir Derrick summed up the limits of regulatory power in the area of efficacy rulings by official regulators thus:

> "I do not believe that opinion on matters of efficacy should be formed by bureaucratic bodies, but rather through the free process of scientific publication, debate and undergraduate and postgraduate education. There is a danger that as regulatory agencies arrogate to themselves more and more the duty of dogmatising on the efficacy of medicines, that a so-called learned medical profession will eventually be reduced to signing forms entitling their patients to obtain such medicines as the regulatory agencies say they may have."

In a parallel vein, the Pharmaceutical Manufacturers Association wrote to the Commissioner of FDA on December 23, 1971, asking for a statement of intention from the agency on relative efficacy. "No authority exists in the stated terms of the statutes authorizing these activities by FDA," PMA President C. Joseph Stetler wrote, "nor is there any implied authority which might be derived from the legislative history of the Act."

Since pursuance of the plan to require relative efficacy statements "would significantly distort the practice of medicine," Stetler asked for an early clarification of FDA's position.

Four months later, in an address to the PMA's Annual Meeting, FDA Commissioner Edwards told PMA that "the physician—and he alone can judge" the choice of medication, and that "FDA does not intend, through labeling, to preempt his judgment." But then he added that "if all drugs are properly labeled, relative efficacy ceases to be an issue."

The question, of course, is what is proper labeling?

It is the general rule for FDA to interpret its regulatory powers very broadly; it may therefore be assumed that some agency personnel might deem it necessary for a "properly labeled" drug product to include relative efficacy information. It is imperative that the professions, the pharmaceutical industry and the public be alerted to the dangers of any official action or unannounced application of such a position by the Food and Drug Administration. There must be general recognition that labeling requirements by FDA in the area of relative effectiveness, to the extent that they are given medical and juridical recognition, would represent a fundamental new departure for American medicine, under Federal control, unlike

(Continued on Page 757)



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1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains f pneumococci, streptococci, and taphylococci, including penicillin-esistant strains. Staphylococcal strains esistant to Lincocin (lincomycin ydrochloride, Upjohn) have been ecovered. Before initiating therapy, ulture and susceptibility studies should e performed. Lincocin has proved aluable in treating patients hyper-ensitive to penicillin or cephalosporins, nce Lincocin does not share ntigenicity with these compounds. lowever, hypersensitivity reactions ave been reported, some of these in atients known to be sensitive to enicillin.

Vell tolerated at infusion site: Lincocin ntravenous infusions have not roduced local irritation or phlebitis, hen given as recommended. Lincocin usually well tolerated in patients who re hypersensitive to other drugs. levertheless, Lincocin should be used autiously in patients with asthma or gnificant allergies.

n patients with impaired renal function, ne recommended dose of Lincocin ould be reduced to 25—30% of ne dose for patients with normal idney function. Its safety in regnant patients and in infants ss than one month of age has ot been established.

incocin may be used with other ntimicrobial agents: Since Lincocin stable over a wide pH range, it is itable for incorporation in ntravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

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Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
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500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatm
Skin and mucous membranes—Skin ras urticaria, vaginitis, and rare instances of foliative and vesiculobullous dermatitis h been reported. *Liver*—Although no direct lationship to liver dysfunction is establish jaundice and abnormal liver function t (particularly serum transaminase) have b observed in a few instances. *Cardiovasc* —Instances of hypotension following pa teral administration have been repor particularly after too rapid IV adminis tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adm istered IV, dilute in 500 ml of fluid administer no faster than 100 ml per h *Special senses*—Tinnitus and vertigo h been reported occasionally. *Local react* —Excellent local tolerance demonstrate intramuscularly administered Linco (lincomycin hydrochloride). Reports of following injection have been infrequ Intravenous administration of Lincoci 250 to 500 ml of 5% glucose in dist water or normal saline has produced local irritation or phlebitis.

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Relative Efficacy — Continued

that found in any other national system. In the end, much will depend on how effectively physicians and consumers express their desire to avoid bureaucratic control of this sort, and how well they demonstrate that such procedures do not serve the public interest.

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The American Society of Gastrointestinal Endoscopy will present a postgraduate course on "Clinical Gastroenterology" at the Castle Harbour Hotel, Tucker's Town, Bermuda, September 10-16. For details, contact Vernon M. Smith, M.D., Director, 301 St. Paul Place, Baltimore, Md. 21202.



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Medical College at Toledo Graduates Its First Class

The Medical College of Ohio at Toledo joined the ranks of the nation's degree-granting medical colleges June 15 with the graduation of its first class of 28 Doctors of Medicine.

The charter class entered the school in September, 1969. The Medical College of Ohio thus became the first of the nation's newly-formed medical colleges to graduate students after an accelerated three-year program, and a curriculum based on "phases" rather than conventional "departmental" courses.

The college is the fourth degree-granting medical school in Ohio, and the 100th active medical college in the nation. It maintains close academic ties with Bowling Green State University and The University of Toledo, but is an independent state-assisted school with its own Board of Trustees.

Thirty-two students entered in the charter class. Five are taking an additional year to complete their work toward the M.D. degree, and one transfer student graduated with the first class.

* * *

Medical College at Toledo Sets Expanded Budget

Trustees of the Medical College of Ohio at Toledo recently announced approval of a $41.5 million budget for the next fiscal year. Of the total, $23.2 million is earmarked for new construction and equipment, and $17.2 million for the operating budget.

MCO vice-president for administration, Howard Collier, said the budget is based on a number of educational and service predictions. These include:

- 30,000 outpatient visits and 20,000 emergency room visits at the Medical College Hospital during the year;
- An undergraduate M.D. enrollment of 135;
- A graduate M.D. enrollment of 121;
- Some reduction in the total number of college employees, and a slight increase in the number of academic employees.

Mr. Collier said $32.5 million, or 79 percent of the new budget, will be derived from state funds. Patient fees are expected to provide $6 million, or 14 percent. The remaining 7 percent will come from all other sources, including Federal grants and contracts.



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OSU Medical Students Will Get First Year Practical Experience

The 227 new students in Ohio State University's College of Medicine will get some practical insights into a physician's role during their first five months of medical school. Classes began July 10 for the new students.

Each medical student will spend two days with a practicing physician in an Ohio community observing patient treatment and accompanying him on hospital rounds. The introductory program, called the "Romance of Medicine," is designed also to give students an understanding of the scope and history of medicine as well as concepts of a physician's role.

On Wednesdays the medical student will meet with a preceptor, who is a medical faculty member to learn about human behavior and relations with patients. "Under the preceptor's guidance, a student interviews patients, for instance, to record medical histories and generally learn how to deal with people from the position of a physician," said Dr. Ernest W. Johnson, director of the "Romance of Medicine" and chairman of the department of physical medicine.

The introductory program began as part of the new three-year curriculum in July, 1970, to give students some practical experiences prior to their final year of medical school, he said. For two years, the program comprised the first month of medical school. This year, the program, which is Phase I of the curriculum, is scheduled each Wednesday for five months. It runs concurrently with Phase II of the four-part curriculum.

In the "Romance of Medicine" students learn emergency medical care because "as soon as someone says he is a medical student, people expect him to know some basics," Dr. Johnson said. "The training has proved valuable in the past — one student who was a passerby was able to save an accident victim through mouth-to-mouth resuscitation."

The program also includes visits to community health agencies to observe how segments of the health care delivery system functions and what problems exist, he said.

The new class is made up of 199 men and 28 women, said Dr. J. Hutchison Williams, assis-

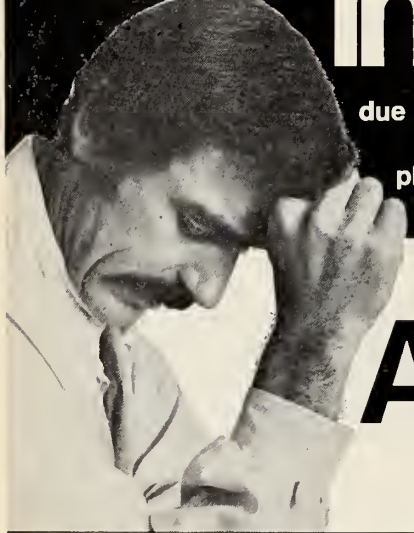
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Fertility and Sterility, January 1970
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Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prio to and during thyroid administration.

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tant dean for medical student affairs. Students were selected from 1,584 applicants, 209 of whom were reapplying.

The number of students is 11 more than last year's class of 216, the limit for two years after increasing from 175. No large increases in class size are planned within the next few years, Dr. Williams said.

Generally, there is a rising number of women applying for admission to the college, which resulted in setting a record of 39 women admitted last year. "We had an unusually high number of qualified women apply in 1971, but this dropped slightly this year," he said.

"Thirteen minority students were admitted, but this is not as many as we would like to have," Dr. Williams said. Of the minority students, 11 are black, one is Oriental, and one is Spanish-surnamed.

The class is the first in several years composed entirely of Ohio residents, he said. Of the 1,584 applicants, 1,208 were Ohioans.

In addition, for the first time the college offers two curricula — an independent study program and a lecture-discussion program. The independent study program, an experimental project for two years known as the Pilot Medical School, was adopted as a curriculum this spring.

Students may select either of the programs for the first 15 months of their education, then the entire class joins for the last 20 months, chiefly clinical experiences.

Dr. Gregory L. Trzebiatowski, assistant dean for medical education development, said 62 students will take the independent study program in which they will learn at their own pace. The program is organized into instructional units, or modules, which the student completes through use of audio-visual aids, computer assisted tutoring and evaluation, and printed material. Faculty members in this curriculum serve as tutors.

Academically, the entering class has a 3.44 grade point average overall and an average age of 22, Dr. Williams said. Thirteen students were admitted after three years of college while 28 have taken studies beyond the bachelor's degree.

Most of the students earned a degree in a science, usually a biological science. Yet nine percent are nonscience majors, representing areas including religion, business, education, philosophy, and political science.

"A popular misconception is that only science majors are eligible for admission to medical school," Dr. Williams said. "The admissions committee does select nonscience majors who show they are capable in the sciences. Medicine is a people-oriented profession and students should have a broad educational background."



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Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

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Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

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Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

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Medical Center at Gallipolis Dedicates New Facilities

DISTINGUISHED GUESTS from all sections of Ohio and neighboring states gathered in Gallipolis on April 17 for the dedication of the new Holzer Medical Center complex, situated three miles west of the downtown area at the intersection of Routes 160 and 35. Some 400 invited guests were among those who attended the afternoon dedication ceremonies, and an estimated 2000 persons viewed the building and were conducted on tours of the facilities for the open house during the late afternoon and evening.

In lieu of the traditional ribbon-cutting, a U.S. Marine Corps color guard participated in a flag-raising ceremony.

Dr. John W. Cashman, Sr., director of the Ohio Department of Health, was principal speaker and brought greetings from Governor John J. Gilligan.

Dr. Charles E. Holzer, chief of staff and son of the center's founder, acted as master of ceremonies. In addition to introducing numerous distinguished guests and principals in the center, he read congratulatory telegrams from U.S. Health, Education and Welfare Secretary Elliot Richardson on behalf of President Nixon, and from Tenth District Congressman Clarence Miller. These were among numerous congratulatory messages received.

The complex represents an investment of some $21 million and sets on 25 acres of ground, with more ground available for expansion. The seven-story hospital has over 252,000 square feet of floor space and is equipped for 265 beds and 30 bassinettes. Parking space is provided for some 650 cars. The adjoining clinic building is a two-story structure with 5,700 feet of floor space.

The move from the old facilities to the new was accomplished late in May and by early June operations at the new site were down to normal procedure. The hospital currently serves a number of counties in southeastern Ohio as well as neighboring areas in West Virginia and Kentucky. Facilities were designed to provide for expanded services through 1985. Already on the drawing board are anticipated expansion plans beyond that period.

It all began in 1909 when the late Dr. Charles E. Holzer, Sr., began converting the home of the late Dr. John B. Alcon, 507 Second Avenue in Gallipolis, into a hospital. The seven-bed facility was opened to the public in 1910. An addition was soon added to the converted house, and in 1913, to meet further demands, the hospital was moved to 535 Second Avenue. Within three years this facility too became inadequate and in 1916 the first wing of the Holzer Hospital facility that was to serve for many years was completed at First Avenue and Cedar Street. In 1926 the hospital's bed capacity was expanded from 35 to 75 beds.

The Holzer Hospital Foundation was formed in 1929, and in 1949 Dr. Holzer, Sr., and his wife transferred ownership of the hospital to the people of the area. Since that year, the institution has been operated by the foundation, a non-profit corporation.

Construction financed by fund-raising drives raised the capacity to 130 beds by 1952, and in 1958 another wing added 70 more beds. On July 1, 1968, after much planning, Holzer Hospital and Clinic merged with the Gallipolis Medical Center to form the Holzer Medical Center. Land was purchased and construction on the new complex began October 15, 1969.

* * *

One phase of the Holzer Medical Center complex is its nurses training program. On June 9 the 49th Commencement exercises for the Holzer Medical Center School of Nursing was held and 25 young women from Ohio and West Virginia received diplomas in nursing.

Advertisement

"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Would it be useful in clinical practice to have government predetermine drugs of choice?

Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

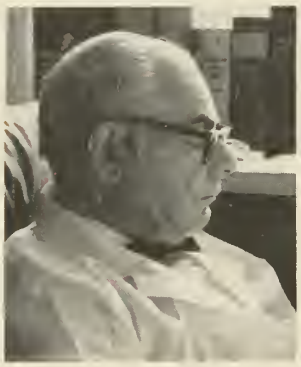
86.7%
No, it would not be useful.

Dialogue

Would it be useful in clinical practice to have government predetermine drugs of choice?

Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really determined.

The Bureau of Drugs suggested the package sert as a possible means communicating informat on relative efficacy of dr to the physician. I find t objectionable, since I not believe the physic should have to rely on t source for final scient truth. There is also a pr tical objection: Since physicians actually d pense drugs, they seld see the package insert. any event, I would ma tain that the physic should know what drug wants and why without pending on the governm or the manufacturer to him.

Undoubtedly, physici are swamped by exces numbers of drugs in s therapeutic categories. I am well aware that m drugs within such ca gories could be elimina without any loss, or haps even some profit the practice of medic But, in my opinion, neit the FDA nor any o single group has the ex tise and the wisdom ne sary to determine the "drug of choice" in areas of medical practic

Maker of Medicine

neth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
li Lilly and Company



n my opinion, it is not function of any governnt or private regulatory ncy to designate a "drug hoice." This determinan should be made by the sician after he has reed full information on properties of a drug, then it will be based on experience with this g and his knowledge of individual patient who eeking treatment.

f an evaluation of comative efficacy were to be le, particularly by govment, at the time a new g is being approved for keting, it would be a at disservice to medie and thus to the patient e consumer. For exam- when a new therapeuagent is introduced, on basis of limited knowle, it may be considered be more potent, more ective, or safer than ducts already on the rket. Conceivably, at s time the new drug ld be labeled "the drug choice." But as addinal clinical experience is umulated, new evidence y become available. er, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the samc class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B_{12} as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use – information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

Opinion & Dialogue

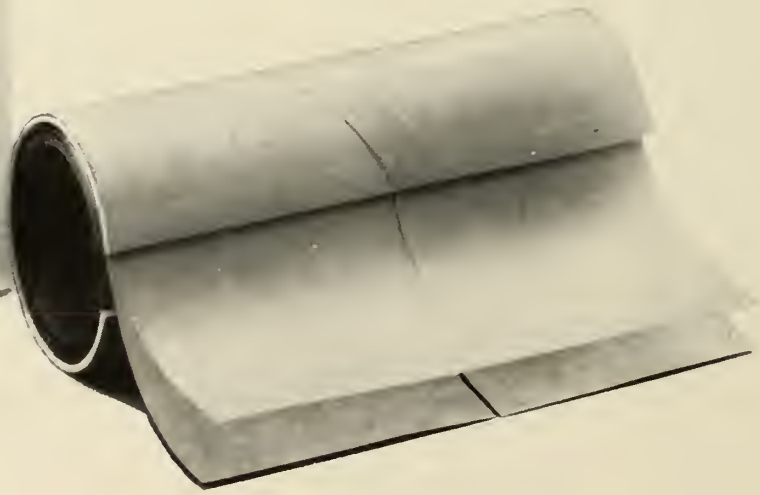
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Clinical & Scientific Features



Volume 68 August 1972 Number 8

A Symposium on Medical History

IT IS A VERY PLEASANT PRIVILEGE to be given the opportunity to be the Editor of this Symposium on Medical History. Dr. Perry R. Ayres, The Editor of *The Journal,* has graciously tendered me his responsibilities, which has made this symposium possible.

The history of medicine has been the blighted child in the large family of medicine. Over the centuries, only a small percentage of time has been allocated to it. More recently, however, an increasing amount of time has been surrendered for this facet of medical knowledge, and certainly an increased amount of interest has occurred. Today there are quite a few history of medicine societies and several journals devoted exclusively to this subject.

Lamentably, there is a great paucity for time in the curriculum of medical schools for the formal teaching of medical history. Genevieve Miller's recent survey of the medical schools of the United States, Canada, and Mexico documents this.

In the State of Ohio alone, there are no formal courses in the four medical colleges. In Cincinnati, three unsuccessful attempts have been made to resuscitate societies over the past several years.

There is one state society—The Ohio Academy of Medical History. This is a subsidiary of the Ohio Historical Society. It meets annually and the programs invariably are eminently good.

It is hoped that the publication of this issue will establish a precedent and that forthcoming issues will recur regularly. *The Journal of the American Medical Association* has established such a pattern which has been in vogue quite successfully for several years.

Do you know that the first Governor of the State of Ohio was a physician and that a town in Ohio was named for him—Dr. Tiffin; that the famous Gatling gun was invented by a graduate from a medical school in Cincinnati; that John Shaw Billings, among other things, was the Librarian of the New York Public Library for 16 years and drew the architectural plans for Johns Hopkins Hospital in Baltimore and the Peter Bent Brigham Hospital in Boston; that there have been 44 medical schools in

the State of Ohio (and in Cincinnati alone there have been 22); and that one of the finest medical history museums in the world is in Cleveland—the Howard Dittrick Museum?

It is hoped that this and subsequent similar issues may initiate and catalyze a desire to search our own attics as well as the attics of our patients for items related to medical history. Just recently, for example, I acquired four original Daniel Drake letters that had been lying dormant in an attic for over 100 years.

Let us proceed.

Cecil Striker, M.D.
Guest Editor

Oral History — New Technique In Medical Historiography

Saul Benison, Ph.D.*

DURING THE PAST DECADE, more than a score of books, embodying a historiographical technic called oral history, have been published in the United States. These books, essentially the memoirs and reminiscences of individuals gathered by historians armed with tape recorders, have with small exception been critically acclaimed. One of the results of this success has been a spate of articles celebrating oral history as a new and unique development in historical practice. Today, almost 22 years after its original inception at Columbia University, oral history projects flourish on well over 100 university campuses, presidential libraries, various government agencies from the National Institutes of Health to the National Aeronautics and Space Administration, as well as in the business world. Yet, save for the tape recorder and television camera which the oral historian uses in his work, there is little that is wholly new or unique about oral history. Its major component, autobiography, has been a facet of western historiography since Greek and Roman times. The interview technics that some oral historians claim as their very own, have long been employed by anthropologists and folklorists in their examinations of preliterate and primitive societies, or by psychiatrists in their explorations of the human mind. In truth, the oral historian works under the same rules that guide all historians. That work can be divided into four parts.

Once a subject has been selected for interview, the oral historian, like any other laborer in the historical vineyard, must prepare himself with a study of extant primary and secondary source materials, in order to identify relevant historical problems. Second, armed with a tape recorder he must use this preparatory work to spur his subject's memory of the past. Third, he must collect from his subject, as well as from other people, supporting documents of contemporary demonstration, both as a check on the tenuousness of memory and to supplement the account gathered. Fourth, he must edit or help the subject to edit, the final preparation of the memoir so that it says what the subject wants it to say.

Although the oral history process is not new, the memoir that emerges from that process is a new type of historical document. It has not only been produced by the participant in past events, it is equally the creation of the historian-interviewer who has, in fact, helped determine the historical relationships to be investigated. Although such memoirs may contain new and even unique information, in no sense are they to be regarded as exclusive historical sources. Actually, they stand as a first interpretation of recent history filtered

*Professor of History, University of Cincinnati, Cincinnati, Ohio.
Submitted November 2, 1971.

through a particular individual's experience at a particular moment in time. As such, it marks the beginning of interpretation not an end. Equally, it marks the first ordering of a mass of primary and secondary material germane to a given individual's life or a series of historical problems.

Dr. Alphonse R. Dochez as Subject

During the past 15 years, oral history has been used to great effect in gathering the recent history of American medicine. In 1955, I had the privilege of inaugurating the Columbia University Oral History Research Office project in the history of American medicine. One of the first people chosen to be interviewed was the late Dr. Alphonse R. Dochez. There was good reason for interviewing Dochez. He was an early graduate of the Johns Hopkins University Medical School, one of the keys to the medical revolution in education that had taken place in the United States since 1890. Also, during his long career, he had been associated with a number of important medical institutions, including the Rockefeller Institute for Medical Research and the Columbia College of Physicians and Surgeons. Most important, he had made distinguished contributions to the development of bacteriology and virology during the first four decades of the 20th century. For example, Dochez was one of the pioneers in the study of pneumococcus and streptococcus. In 1924, almost simultaneously with George and Gladys Dick, he helped establish the streptococcus as the cause of scarlet fever. Subsequently, he made equally important contribution to our understanding of the nature and activity of influenza virus.

Among the key problems I addressed myself to in my interviews with Dr. Dochez were the factors that led to his development as a bacteriologist. These I discovered were in large measure fortuitous. As the 13th man in his graduating class in 1908 at the Hopkins, Dochez just missed a coveted appointment as an intern at the Johns Hopkins Hospital. A chance meeting with Dr. William MacCallum in a corridor of the medical school, led to an appointment as an assistant in the department of bacteriology at Johns Hopkins. It was his work with MacCallum that opened the door to an appointment at the Rockefeller Institute in the following year. Initially Dochez worked with Dr. Eugene Opie on problems of autolysis of the liver and the proteolytic enzymes of the pancreas. He undoubtedly would have continued this work but for the fact that in 1910 Dr. Opie transferred to the George Washington University in St. Louis. Left without a job, Dochez approached Dr. Simon Flexner, then the director of the Rockefeller Institute, for reassignment, and was given a post with Dr. Rufus Cole, the newly appointed director of the then recently opened Rockefeller Institute Hospital. Although Dochez had little training in bacteriology, Dr. Cole put him to work as a bacteriologist assisting Dr. Francis Peabody in the care of pneumonia patients at the hospital. The excerpt that follows from Dr. Dochez's oral history memoir, now stored in Special Collections of the Columbia University Library, details the beginning of his pneumonia research.

The Process of Pneumonia Research at the Rockefeller Institute

"I can't remember much about the first year. We took in a great many cases of pneumonia. They were all very bad, because the doctors had a way of sending in the bad cases. We had a very high mortality, so that Peabody and myself were both quite discouraged from that standpoint at the end of the year. But much time was also given over to isolating the pneumococcus from the cases of pneumonia that came in and studying it. More particularly, I devoted my time to studying the frequency with which the blood was invaded by the pneumococcus, since that seemed to be a very bad feature from the standpoint of the patient. If the organism got into the blood, he was much more likely to die than if the organism didn't get into the blood. So we made many blood cultures and related the occurrence of a positive blood culture to the outcome of the case. At the same time, we kept all the strains of pneumococcus that we isolated from the patient in order to study them, to infect animals with them, and to study their virulence, and so forth. The first year was devoted largely to that. The work I did in the laboratory was rather desultory.

"The principal thing that Dr. Cole was interested in was phagocytosis of the organism by the white cells of the blood. The organism is not readily taken up by the white cells of the blood and requires a serum component to promote phagocytosis. We worked on that for the first year, but we didn't make much progress in it. This was a time when bacteriologists and pneumologists were much interested in what were known as opsonins and bacteria tropines, which is an immune type of opsonins. We did a little study of that to find out how significant that reaction was. We didn't really find out very much, because the pneumococcus is not readily picked up by the white cells of the blood. It repels them. 'They don't phagocyte,' as we say. So the outcome of those studies was not very significant beyond the fact that we collected a large number of organisms and got a fairly good record of how fre-

quently they penetrated the blood and the effect of penetration of the blood on the outcome of the disease itself. . . .

"At that time we had collected a great many strains of pneumococcus from pneumonia. We knew how to get them from the lung, and we knew how to get them from the blood. As I watched the clincial course of the disease the thing that impressed me was the character of the crisis. In pneumonia, the fever will continue very high for six to ten days and more, and then, in a number of instances, it drops suddenly almost to normal. When it does that, the urgency of the situation disappears, and the patient is pretty well. I had seen quite a lot of that, and I thought that something pretty significant must happen at that time, and that if it did, we should find out what it was. I hasten to add there was nothing original about this, because work of that kind had been done before. In Germany work had been done indicating that as an individual recovered from pneumonia immune bodies to the pneumococcus were formed. . . . But the studies had not been very complete nor very systematic. We then undertook to make a systematic study.

"We proceeded in this way: we worked on the concept that if immune bodies were formed at the time of recovery those immune bodies would be most active against the organism which infected the individual, so that the first thing we had to do when a patient came into the hospital was to isolate the organism that was causing his pneumonia, either from his sputum or from his blood—if it happened to be present in the blood. That organism was then adapted to mice so that it would be highly virulent for mice, so that injection into the peritoneal cavity of a mouse in very small amounts would kill the mouse quite promptly.

"Then we took specimens of blood from the patient every day up to the time through the crisis and then at variable intervals after the crisis for a period of two weeks. By this time, we had the materials which were necessary to find out what happened in the way of the development of immunity at the time of the crisis. We then took the organism which we had isolated from the patient, mixed it with the various specimens of serum which we had obtained at different intervals throughout the course of the disease, and injected that mixture into mice to see at what stage the serum would protect mice against this experimental infection.

"We found that the immune bodies which were capable of protecting mice appeared at about the time of the crisis in varying degrees of concentration. At some times the amount present was quite large, and at others it was very small. But, more or less over a period of time, it was possible to show that, in general, at the time of the crisis immune bodies appeared in the patient's serum which were capable of protecting mice against experimental infection.

"That, of course, then indicated and set the stage for what was to be done next, because it was a fair assumption that the development of antibodies at the time of crisis had something to do with the recovery.

Serum Treatment of Patients

"In view of the fact that we were clinicians, our primary objective, of course, was to discover some method of controlling and curing the disease. We knew, from work done by other people and work done by ourselves, that if we injected animals with the pneumococcus we got immune bodies that were very similar in their capacity to protect to those that were found in the patient at the time of recovery. We then began to consider how we might supply these antibodies artificially. Dr. Cole was greatly interested in that. In a sense, that was his primary interest in the whole activity, which, of course, as the director of the hospital, he advised and supervised.

"We followed the usual procedure of obtaining antibodies of that type for the human disease, and we got horses and injected them with the pneumococcus over a period of time. Very shortly we found that when we did that the horse's serum developed a very high capacity for protecting mice against experimental infection. After that was done, we next took the decision that we would treat patients with that serum to see if it had any effect. This had been done many times before, but it wasn't done, as I remember, in quite the way in which we did it, because before individuals were not immunized with pneumococci of unknown immunological characteristics. We collected a large number of pneumococci from all the patients that came to the hospital, and then we tested them to see what their immunological characteristics were. We used as a standard strain the sample we had obtained from Neufeld, in Germany, who had also done a certain amount of work along this line. We found that by use of his standard strain, which was called number one, that that was the principal cause of lobar pneumonia in this country. There were others, but that was the principal one. There was another, which we called number two, which was fairly frequent, and there was another one called number three, which was also fairly frequent, but it was impossible to produce an immune serum at the time to number three, so we were limited to the serums produced against numbers one and two. The number one serum was the first one we used.

"In general, the amount of crude horse serum

that had been injected intravenously into human beings up to that time had been relatively small at any one time. We felt that it would be necessary to give a considerable amount. That presented us with quite a problem. I searched through the literature on the question, and I think I found one or two examples where large amounts of horse serum had been given to individuals intravenously without serious complications of any kind.

"After we developed our serum to the potency which we wanted it to reach, we decided to inject the first patient, not knowing quite what might happen. We were, it must be remembered, giving exceedingly large amounts quite systematically, much larger than had ever been given before as a formal treatment.

"I will never forget the first patient that was treated. I asked Dr. Homer Swift, who was in the hospital and had had a good deal of experience in the intravenous injection of serum into patients, to stand by when I made the first injection. Yet Swift's experience, although wide, was limited to studying the effect of certain kinds of human serum on syphilis. Our patient was a young man who had a fairly severe case of pneumonia, but who was not desperately sick. Dr. Swift stood on one side, and I worked on the other and injected the serum into the arm vein. First I went very slowly, because we wanted to be prepared for some sudden accident. Well, we injected about half of it when the patient said, 'I feel funny.' I looked at him, and his face had become very red. I stopped immediately, but I didn't take the needle out of the vein. I thought, 'Now we're in for it; something is going to happen.' We waited five minutes or perhaps ten, and I said to Swift, 'What shall I do next?'

"He said, 'Go ahead,' so we went ahead with the rest of it, and nothing more happened. The man was quite comfortable throughout the rest of the injection. I don't remember at what time of day that was given, but we gave him at least one more injection that day of a similar amount, which was 100 cubic centimeters, a very large amount of foreign serum to put into the human body.

"The next day, then, we all trooped up into the ward as soon as Dr. Cole arrived to see what happened. Lo and behold, the patient's temperature had dropped to normal, and he felt much better. Our first experiment was unexpectedly successful in that it brought the patient's temperature down and improved his condition. The improvement persisted, although I think we perhaps gave him one or two more treatments to prevent a relapse. This first case, which occurred about the end of 1912, was very encouraging."

Dochez's reminiscences of the origins of pneumonia research at the Rockefeller Institute can in no way be characterized as definitive. At best it opens the door to further inquiry. It does, however, preserve the environment in which the events took place, and above all, the human quality of Dochez and his colleagues. It is this characteristic which marks the importance of oral history as a device for capturing the recent history of medicine. It preserves the humanity of the larger historical tendencies and movements we have come to celebrate. As such it allows us to probe not only the achievements of great physicians and medical scientists but also the lives of ordinary medical practitioners, as well as that long-forgotten element in the history of medicine—the long suffering patient.

* * *

E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 37-year-old man enters your office with a three-month history of progressive hoarseness. Originally, this was associated with a sore throat and an upper respiratory infection. All of his symptoms cleared except the hoarseness. The patient smokes 40 cigarettes a day.

Physical examination reveals his pharynx to be injected. When an attempt is made to visualize the patient's larynx with a mirror, he gags violently and you are unable to complete the laryngeal examination.

What would be your next step in evaluating this patient?

(See p. 785 of this issue for further information and discussion.)

*Dr. Miglets, Columbus, is Assistant Professor of Otolaryngology, The Ohio State University College of Medicine.

Submitted February 28, 1972.

The *Pharmacopoeia Reformata* of London (1744) and Its Anonymous Author

Alex Berman, Ph.D.*

WILLIAM HEBERDEN'S famous attack in 1745 on mithridatium and theriaca has tended to overshadow another significant proposal emanating from a member of the London medical establishment to purge the Pharmacopoeia. This was the appearance a year earlier, in 1744, of an anonymous work entitled *Pharmacopoeia Reformata: or an Essay for a Reformation of the London Pharmacopoeia.* Only the initials M.S. on the dedicatory page give any clue to the identity of the author, who respectfully dedicated the book to the President, Censors, and Fellows of the Royal College of Physicians in London in "an attempt to provide the Reformation of their Pharmacopoeia."

This work by M.S. was essentially a critique of the draft for the fifth edition of the *London Pharmacopoeia* (1746) produced by the College's Committee on Revision. In his preface (page 6), M.S. concluded: "There appears likewise still too great a regard paid by the Committee to some compositions valuable for little more than their antiquity. Upon the whole, the draught for a new Pharmacopoeia which the Committee have favoured us with, stands in need of many essential alterations and amendments, before it becomes worthy of the sanction of the College."

The fourth edition of the *London Pharmacopoeia* (1721), in addition to many bizarre remedies, had other serious shortcomings, such as ambiguity in the use of weights and measures and inadequate directions for compounding. As M.S. stated: "Many medicines are directed in their book in a manner so repugnant to the rules of Pharmacy, that the apothecary is justly to be excused in compounding medicines otherwise than as directed by the College; and that no physician could without impeachment of his judgment, insist upon the Pharmacopoeia being exactly complied with" (page 8). That members of the College had to seek pharmaceutical advice from apothecaries infuriated the author; he felt that all physicians should have a good knowledge of practical pharmacy: "But surely this condescension is beneath the dignity of the faculty of physick. Is it not ridiculous to apply for assistance to those whom you have undertaken to direct? Is the knack of prescribing medicines to be learnt only from the servile labours of the shop . . .?" (page 9).

After listing some guidelines for the selection of pharmacopeial drugs and giving a short abstract of the proceedings of the Revision Committee, M.S. launched into his criticism of the Committee's draft for the new Pharmacopoeia.[1] Despite his vigorous objections, a number of traditional remedies recommended by the Committee were accepted in the 1746 Pharmacopoeia. The observations of M.S. would clearly indicate that he belonged in the progressive company of Heberden. Consider the following examples of the Committee's recommendations and the author's reactions:

Pulvis Antilyssus or "Powder Against the Bite of a Mad Dog," consisting of ash-colored ground liverwort *(Lichen caninus L.)* and black pepper, was recommended for retention by the Committee. M.S. criticized this decision on the grounds of insufficient clinical evidence for efficacy: "It is greatly to be wished, that the efficacy of this medicine, in preventing the terrible disorders occasioned by the bite of a mad dog, was certain and proved by incontestable facts. Certainly it would well become the dignity of the Royal College of Physicians of London to make the most exact

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inquiry into the merit of every remedy, before they received it into their Pharmacopoeia" (page 152).

Pulvis e Chelis Cancrorum Compositum or "Compound Powder of Crabs' Claws," which was prepared from the tips of crabs' claws, pearls, and red coral, was accepted in the new *London Pharmacopoeia* (1746) along with a *Pulvis Bezoardicus* or "Powder of Bezoar." In his opinion of these drugs as they appeared in the Committee's draft, M.S. rejected bezoar as ineffective and too expensive and dismissed the other ingredients as "too absurd to deserve a particular comment" (page 155).

The old *Confectio Raleghana,* or "Sir Walter Raleigh's Confection" which rivaled mithridate in the number of ingredients, came in for criticism by the Committee, which called it "the most redundant of the modern compositions admitted in our Pharmacopoeia"; but after making some minor changes, they timidly submitted this medication virtually intact for the consideration of the College. M.S. responded harshly: "It is very extraordinary that the Committee, after the remarks . . . which they have favoured us with, should proceed no farther in correcting this composition, but refer it to the consideration of the College, with a bare wish that it might be reformed to a just simplicity. For this medicine tho' much in use, does not appear, from the effects which it produces, to be of importance enough to deserve much consideration . . . It would be as tedious to the reader as unpleasant to myself, to criticise on the various ingredients of this exuberant composition" (page 171). This medication, considerably modified, entered the 1746 Pharmacopoeia under the name of *Confectio Cardiac,* or "The Cordial Confection." Perhaps the strictures of M.S. helped bring this about.

Finally, it is interesting to note the author's rejection of mithridatium and theriaca, two medications which symbolized for him, as they did for Heberden, the outmoded "sacred relicks of antiquity." The Committee had conceded in its draft that "These celebrated compositions might without doubt be reduced without any diminution of their virtues," but then backed off on the grounds that "the effects of them in their model are so well known, so much regard has been paid to ancient authority as not to attempt a reformation of that kind" (page 176). M.S. was scathing in his criticism: "To receive without alteration irrational compositions, and which we have publickly condemned, must shew either that the art of prescribing compound medicines is built on false principles, or rather none at all, or else that we are blindly leaning to an unphilosophic superstition, in spite of all the light and information that time has poured upon us" (page 182). More than 40 years would elapse, however, before the Royal College of Physicians finally expunged them from the *London Pharmacopoeia* of 1788.

Who was M.S.? It is possible that the author was a Jewish physician, Meyer Loew Schomberg (1690-1761), who was born in Fetzberg, Germany, received his M.D. degree in 1710 from the University of Giessen, and was admitted a licentiate of the Royal College of Physicians of London in 1722.[2] By 1740, Schomberg had become one of the most successful medical practitioners in the English capital. One of his sons, Isaac Schomberg (1714-1780), was embroiled for years with the College in a quarrel over licensure.[3]

The evidence for this tentative assumption rests mainly on the fact that "Meyer Schamberg" [sic] appears among the licentiates *(Permissi)* in the *London Pharmacopoeia* (1746), that no other member of the College has the initials "M.S.," and that Schomberg undoubtedly had available the pharmacopeial draft and narrative of the proceedings of the Revision Committee.[4]

Most prominent in compiling the 1746 Pharmacopoeia were Dr. Plumptre, the President of the College; Drs. Crowe, Freind, Heberden, and Mead, as well as Dr. Henry Pemberton, who was frequently consulted.[5] The preface of the new Pharmacopoeia of 1746 pointed out that the College had attempted to rid itself of medicines which the ancients had "superstitiously and doatingly derived from the oracles, dreams, and astrological fancies," but ended by frankly admitting that "in some things we have submitted to the prevalence of custom and have left them to the correction of posterity."[6] This capitulation was doubtless made over the strenuous objections of Heberden, and certainly of M.S.

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1. The complete narrative of the proceedings of the Committee was published by Henry Pemberton in *The Dispensatory of the Royal College of Physicians,* London: 1746, pp 1-126.
2. For more biographical information about Meyer Schomberg, see *Dictionary of National Biography* XVII:925, 1921; W. Munk: *The Roll of the Royal College of Physicians of London* (ed 2) London: 1878, pp 21-82; and E R Samuel: "Dr. Meyer Schomberg's Attack on the Jews of London," in *Transactions, The Jewish Historical Society of England*: 20:83-100, 1959-1961.
3. Clark, Sir George: *A History of the Royal College of Physicians of London,* II, London: 1966, pp 547-551.
4. *Pharmacopoeia Collegii Regalis Medicorum Londinensis,* London: 1746, p xiv. Regarding the distribution of the Committee's draft and narrative to all members of the College, see *Pharmacopoeia Reformata,* p 13, and Pemberton's translation, *The Dispensatory of the Royal College of Physicians,* 1746, p 1.
5. Wootton AC: *Chronicles of Pharmacy,* II, London: MacMillan & Co. 1910, pp 67-68, and Matthews LG: *History of Pharmacy in Britain,* Edinburgh: E & S Livingston, 1962, p 79.
6. "Preface of the College" in Pemberton's translation, pp viii-ix (see Ref. 4).

Some Ohio Physicians Who Contributed to Natural History

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THE FIRST NATURAL SCIENTISTS came very largely from the ranks of physicians. For a long period of time, the only university training of a scientific nature was in the field of medicine. At one time, preparation for a medical career included the study of botany as a background for materia medica and a study of zoology as a background for specialized work in anatomy and physiology. Some physicians found their background training in the biological sciences sufficiently stimulating to continue such studies as an avocation. Also, before the universities were diversified, a person interested in scientific pursuits had no choice but to study medicine even though he may have had little or no intention to practice medicine. Consequently, for several centuries of time, we find many of the pioneers in the natural sciences were trained in medicine. This trend continued through the 19th century. In this article, a thumb-nail sketch will be given of some selected Ohio physicians who made significant contributions to the development of natural history. Many sources have been consulted, but special acknowledgment should be made to Kelly and Burrage[1] and to Hume.[2]

Dr. Jared Potter Kirtland

Dr. Jared Potter Kirtland (1793-1877) was born at Wallingford, Conn. and studied in the local academies. He was raised primarily by his grandfather, Dr. Jared Potter, who stimulated an interest for medicine and natural history in his namesake. As a boy, he developed horticultural skills, including grafting, cross fertilization, and cultivation, and also the care of honey bees and silk worms. At the age of 15 years, this young naturalist, by his own experiments, discovered parthenogenesis in the silkworm moth.

In 1810 he joined his father at Poland, Ohio, a new community which his father had founded. There the young son experimented with his father's bee colonies and collected mollusks from the nearby Mahoning River. After teaching school for a year, he returned to Connecticut to study medicine as an apprentice. In 1813 he entered the first class at the Medical Institute of Yale University with funds willed to him by his grandfather for his medical education. The following year, he studied medicine at the University of Pennsylvania under Dr. Benjamin Rush and studied botany under Benjamin S. Barton. His MD degree, however, was granted from Yale in 1815. After practicing medicine at Wallingford for 2½ years, and continuing his studies in natural history, he returned to Poland, Ohio for another year, but he resumed medical practice at Durham, Conn. for the next five years. After the tragic death of his wife and young daughter in 1823, he returned to Poland to practice medicine and to continue his studies on the mollusks of Ohio.

In 1829 he was the first to discover separate sexes in the river clams (Unionidae). In 1840 he published his discovery of byssal threads in the larval stages of river mussels.

In 1836 he was placed in charge of zoology for the First Geological Survey of Ohio. He worked particularly with mollusks, fishes, reptiles, birds, and mammals. He described many new species of fishes and illustrated his own publications. In 1838 his "Report on the Zoology of Ohio," was published in the *Second Annual Report of the Geological Survey of Ohio*. As a member of the Boston Society of Natural History, he published frequent contributions to its proceedings. In 1837 he bought a farm at East Rockport (now Lakewood), just west of Cleveland. Here he developed an experimental garden, nursery, orchard, and arboretum where he carried out original investigations in plant propagation. He developed many new horticultural varieties of fruits, especially cherries.

Between 1837 and 1842, he taught theory and practice of medicine at the Ohio Medical College in Cincinnati, and in 1841 and 1842, he taught theory and practice of medicine and physical diagnosis at the Willoughby Medical School. Following this, he became a founder of the medical de-

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partment of Western Reserve College in Cleveland, where he was a professor of medicine for 21 years and at one time served as President of the Ohio State Medical Society.

Dr. Kirtland was a founder of the American Society of Geologists and Naturalists (1840), which five years later became the American Association for the Advancement of Science. Also at that time, he was elected to the board of managers of the Smithsonian Institution in Washington. That same year, he established a museum at the Western Reserve Medical School and organized the Cleveland Academy of Natural Sciences which took care of the collections in the museum. Dr. Kirtland served as president for 20 years, and in 1869 it became known as the Kirtland Society of Natural History. Eventually, this became the Cleveland Museum of Natural History. The history of this organization has been traced by Walter Hendrickson (1962).[3]

Dr. Kirtland popularized interest in natural history by lecturing and writing in addition to his scientific investigations. He wrote a regular column entitled, "Fragments of Natural History" in the newspaper, *Family Visitor*, of which he was a founder and editor (1850-1853). This was published simultaneously in Cleveland and Hudson, sites of Western Reserve College and Western Reserve Academy.[3] He also contributed many articles to the *Ohio Farmer,* and served as the first president of the Cleveland Horticultural Society. He became widely known as the "Sage of Rockport." When he died at his farm, in 1877 at the age of 84, he was known as Cleveland's first and most famous naturalist. A special issue of *The Explorer* was devoted to Dr. Kirtland based upon the work of A. R. Gehr.[4]

Dr. John Leonard Riddell

Dr. John Leonard Riddell (1807-1867) was born in Leyden, Mass. and graduated from the Rensselaer Institute at Troy, N.Y., where he became a lecturer in science. In 1835 he became the adjunct professor of chemistry and botany at the Cincinnati Medical College. The following year he completed his MD degree at that institution, and about that same time, published a volume on *Geological Features of Ohio.* That same year he published his catalog of plants entitled *A Synopsis of the Flora of the Western States,* which is one of the pioneering works on Ohio flora. Also, in 1836, he became professor of chemistry in the medical department of the University of Louisiana, and while there, he published a catalog of Louisiana plants.

The genus *Riddellia* was named in his honor by another pioneer Ohio botanist, Thomas Nuttall. Waller has published an appreciation of the life and work of Dr. Riddell.[5]

Dr. Edward Hamilton Davis

Dr. Edward Hamilton Davis (1811-1888) was born in Ross County, Ohio, and prophetically attended a school located on an Indian mound near Circleville. While an undergraduate student at Kenyon College, he explored Indian mounds in the vicinity and presented an original paper on his study at his college commencement in 1833. He earned his MD degree at the Cincinnati Medical College in 1838, and after practicing medicine in Chillicothe until 1849, settled in New York City, where he became professor of materia medica at the New York Medical College.

Before leaving Ohio, he had been encouraged by Daniel Webster to continue his studies of the Indian mounds. In 1845 he was joined by E. G. Squire as a collaborator. Dr. Davis was responsible for most of the field work, while Squire edited his notes and prepared maps and drawings to illustrate the field survey. Together they published *Ancient Monuments of the Mississippi Valley,* which became the first volume of the *Smithsonian Contributions to Knowledge* in 1848. Because Squire did the editorial work, Joseph Henry, Secretary of the Smithsonian Institution, placed his name as senior author in spite of the fact that Dr. Davis was responsible for most of the field work and personnally financed the project. Eventually, the artifacts were sold to an Englishman who built a special museum near Salisbury to house the collection.

Dr. John Aston Warder

Dr. John Aston Warder (1812-1883) was born near Philadelphia, Pa. He was stimulated in the studies of nature by his father and by John James Audubon, who was a friend of the family. In 1830 the family moved to Springfield, Ohio, and four years later, young Warder entered the Jefferson Medical College where he earned his MD degree in 1836. The next year he began the practice of medicine in Cincinnati where he became active in the Cincinnati Society of Natural History. Hendrickson has described the early history of natural history in the Cincinnati area.[6,7] Between 1854 and 1857, Dr. Warder served as professor of chemistry and toxicology at the Medical College of Ohio. At that time he took up residence in North Bend, Ohio, which remained his home to the end of his life.

He was especially interested in forestry and became a member of the Ohio State Board of Agriculture. He described a new species of tree known as *Catalpa speciosa.* In 1867 he published a volume on apples as part of the series *American Pomology.* In 1873 he served as a United States Commissioner to the Vienna Exposition. His official report on forests and forestry, prepared in connection with the exposition, stimulated interest in forestry throughout the United States.

Dr. John Strong Newberry

Dr. John Strong Newberry (1822-1892) was born in Windsor, Conn., but as a child was taken to Cuyahoga Falls, Ohio, where his father was one of the founders of that community. He attended Western Reserve College at nearby Hudson where he graduated in 1846. Two years later, he completed his MD degree at the Cleveland Medical College. This was followed by two years of travel in Europe and in the United States. In 1851 he returned to Cleveland to practice medicine but was actually more interested in the natural sciences than in his medical career. In 1855 he got his great chance to combine his medical training with his interest in geology when he was appointed Acting Assistant Surgeon and Geologist for the United States Exploring Expedition sponsored by the War Department. The initial objective was to explore the area between San Francisco and the Columbia River. In 1857 and 1858 the party explored the Colorado River. With this experience, he became (in 1866), professor of geology and paleontology in the School of Mines at Columbia College in New York where he remained on the faculty for the rest of his life.

Between 1869 and 1875 he served as State Geologist for Ohio and organized the new State Geological Survey. In his capacity as director, he published a series of annual reports for the Ohio Geological Survey. In 1884 he was appointed Paleontologist to the United States Geological Survey and was in charge of the work on fossil fishes and plants.

Dr. Newberry was a member of the Ohio State Medical Society and an incorporator of the National Academy of Sciences, as well as serving as president of the New York Academy of Science.

Dr. Casey Albert Wood

Dr. Casey Albert Wood (1856-1942) was born in Wellington, Ontario. He first studied medicine with his father, and then he graduated in 1877 from the Medical Department of Bishop's College in Montreal. The MD degree was awarded him by McGill University in 1903. He had special training in ophthalmology both in the United States and in Europe. He served on the staff of two hospitals in London, and in 1890 was appointed professor of ophthalmology at the Chicago Post-Graduate Medical School. Between 1898 and 1906 he was professor of clinical ophthalmology at the College of Physicians and Surgeons, and for the next two years, he was head of the department of ophthalmology at Northwestern University. He held the same position at the University of Illinois between 1909 and 1913. For many years he was editor-in-chief of *Annals of Ophthalmology*, served as an editor of the 18-volume *Encyclopedia on Ophthalmology,* and translated classical works in ophthalmology written in both Latin and Arabic.

At the outbreak of World War I, he headed the examining unit for the aviation section of the U.S. Army Signal Corps, which was centered in Chicago. In the fall of 1917, he was in charge of the eye department at Camp Sherman in Ohio. After the war, he was made a Colonel in the Medical Section of the Officer Reserve Corps.

In 1927 Dr. Wood was appointed honorary collaborator on birds at the Smithsonian Institution, and the following year he became honorary lecturer on ornithology at Stanford University. Four years later, he was appointed research associate at the California Institute of Technology. He published many papers on birds in all of the ornithological journals and in many popular magazines. His interests in birds was world-wide, and he held membership in several foreign ornithological societies as well as in the United States. He was also a student of medical history and served as associate editor for *Annals of Medical Hitsory.* He collaborated with Col. Fielding H. Garrison (U. S. Army Medical Corps) in editing a volume entitled *A Physician's Anthology,* published in memory of Sir William Osler. Dr. Wood was a student under Osler and aided in the preparation of his *Festschrift.*

As might be expected, Dr. Wood did special research on the eyes of birds about which he published many papers. He also published material about the birds found in many parts of the world where he had travelled. He made many contributions to the Osler Library of Historical Medicine, and his own collections and books on birds now form the nucleus of the Wood Library of Ornithology at McGill University which he endowed.

Brief accounts of two other Ohio physician-naturalists have recently been published by the writer.[8,9]

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Ohio Physicians — Landmarks

Bruno Gebhard, M.D.*

THERE ARE FAR TOO FEW landmarks preserved or historical markers erected to honor Ohio's outstanding physicians. For instance, there is no visual reminder in Waynesville, Warren County, of the birthplace of John Evans (1814), who during his active life became a physician and the second Governor of the Colorado Territory. Mt. Evans was named in his honor and also Evanston, Ill. of which he was the founding father as well as of Northwestern University.

Auburn Corners (Geauga County)
At the cemetery near Rt. 422 is a white marble monument honoring Dr. Oliver W. Ludlow, born in New York State on January 1, 1800. He practiced medicine in Newberry from 1843 until his death in 1865.

Austinburg (Ashtabula County)
Sardins Brewster, a direct descendant of the Elder William Brewster of Mayflower fame, was born in 1785 and studied medicine with his elder brother Oliver in Pittsfield, Mass.; he was the first physician settling in Austinburg.

Alliance (Stark County)
Well-to-do Dr. Levi L. Lamborn put a red carnation, then a rarity, into the buttonhole of the campaigning William McKinley; it became McKinley's good-luck charm. In 1904 the carnation became the state flower.

Akron (Summit County)
Streets are named for the following physicians, more for their importance in business than in medicine: Eliakim Crosby (1779-1854), Stephen H. Coburn (1809-1888), Arthur M. Cole (1855-1922).

Benjamin Franklin Goodrich (1841-1888), sixth descendant from the colonist W. Goodrich, enrolled in Cleveland Medical College at the age of 18 years, graduated in 1861, served in the Civil War as a surgeon, and gave up the practice of medicine for good in 1864; started the B. F. Goodrich Company in 1867 which first manufactured besides fire hoses, washing wringers, dental plate rubber, and anesthesia gas bags.

Athens (Athens County)
Manasseh Cutler Hall, built in 1817 on the campus of Ohio University, was named for the Massachusetts-born physician-lawyer Manasseh Cutler (1742-1823).

Attica (Seneca County)
Samuel B. Smith (1871-1937), the physician who unseated the hen with his mammoth mechanical incubator, lived here.

Bratenahl (Cuyahoga County)
The original Salisbury Avenue, since 1906 a part of Lake Shore Boulevard, was named after James H. Salisbury, M.D. (1823-1905), and after whom the Salisbury steak is also named.

Butler (Richland County)
"Dr. F. A. Reed—In memory of our faithful country doctor. He began practice with this sign in 1903 in Felloway, Ohio; in Butler, Ohio from 1925-1968."—so reads the memorial plaque in Butler Park.

Celina (Mercer County)
Was founded in 1834 by Rufus W. Stern, the first resident physician of nearby St. Mary's; it was originally named Salina.

Canton (Stark County)
Unique since 1967 for the United States is the street name "Christmas-Seal-Drive." The office of the Stark County Tuberculosis Society is located at No. 13.

Cincinnati (Hamilton County)
Memorial plaque to Richard Allison, M.D. (1757-1816), first practicing physician in

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Cincinnati at the northeast corner of Third and Lawrence Avenue. It reads in part: "On this site Doctor Richard Allison built his 'Peach Grove' house about the year 1795 . . . he was a veteran of the American Revolution and the Indian wars . . . he was an ornament to his profession . . . in his bounty distress found relief and in his generosity, unfortunate merit repose."

There is no street named for Daniel Drake, nor any other physician. There is a monument for Daniel Drake at his burial site at Spring Grove Cemetery and also a Daniel Drake Memorial Hospital.

Harvey Wicks Felter, M.D. (1865-1927); a game preserve is named for this physician. He was a professor at the Eclectic Medical College.

John Sellmann, M.D., his grave at Spring Grove Cemetery was unmarked for 80 years; he died in 1826. A United States government marker was placed at the grave site in 1940. Dr. Sellmann was a Revolutionary War soldier in the First Maryland Regiment, and was the first president of the Cincinnati Medical Association.

Cleveland (Cuyahoga County)
The "Forest City" had, till 1906, a Longstreet and a Long Avenue honoring Cleveland's first physician; also a Kirtland Street that is now 49th Street. A public memorial tablet, commemorating the birth of Harvey Cushing, M.D. (1865-1939), was unveiled at the Centennial at the entrance of the May Company on Public Square, the former site of the Cushing family home.

Christian Dellenbaugh, M.D., was born in North Georgetown, Columbiana County, in 1830; he came to Cleveland in 1856. He was very active in medicine, real estate, and in Republican politics; he became the first mayor of East Cleveland. Dellenbaugh Avenue is named for him.

Cleveland Mountain in Michigan was so named by John Lang Cassels, M.D. (1808-1879), Dean of the Willoughby Medical School and of the medical department of Western Reservice University. He was a noted chemist and explored the Lake Superior region successfully for copper, silver, and iron ore.

Columbus (Franklin County)
Goodale Park and Goodale Street are named for Columbus' first physician, Dr. Lincoln F. Goodale (1782-1868). After fighting in the War of 1812, he entered commerce for the rest of his life. In 1851 he donated 40 acres of woodland on the northern boundary of the city. In 1888 a bronze bust was executed by F. Q. A. Ward for the park.

Samuel Mitchell Smith, M.D., had a bronze statue with a drinking fountain erected in his honor at the corner of Broad and High Streets, later removed to St. Francis Hospital, and now on the lawn of the City Health and Safety Building.

Dayton (Montgomery County)
A memorial tablet to John Charles Reeves, M.D. (1826-1920) in the public library reads: "Student–Writer–Thinker–Scholar–'Doctor of the Old School'–Abreast with the Times–The First to use the Clinical Thermometer–the American Pioneer in Anesthesia by the use of A.C.E.–to his Memory This Tablet is erected by the Montgomery County Medical Society (1937)."

Jenera (Hancock County)
Was named for H. B. Jener, the first physician in that county.

Fort St. Clair (Preble County)
A roster of physicians' and surgeons' mates who served under Richard Allison, M.D. in the Indian Wars in the Army of the United States or the Kentucky Volunteers was erected as a plaque near Eaton, Ohio in 1953.

Geauga County
George Crile, M.D. (1864-1943) has a Crile Road named after him in this county, also a public school in Cleveland; the former Veterans Hospital in Parma Heights during World War II was called Crile Hospital. The new building on East Boulevard does not carry his name.

Hambden (Geauga County)
Was originally called "Bondstown" after Dr. Solomon Bond, one of the earlier settlers, the name was changed by popular vote in 1817.

Lafferty (Belmont County)
Was named after Dr. Joseph Lafferty in 1880.

Lakewood (Cuyahoga County)
Kirtland Lane (1921) is situated near Lake Erie on the original farm site of Dr. Kirtland's home.

Fry Avenue is named in honor of Dr. Richard Fry, who practiced medicine in Chagrin Falls, then taught in the Cleveland Public Schools for 17 years. Retiring in 1868, he bought 27 acres of land in the vicinity of the street named for him.

C. Lee Graber, M.D., the founder of Lakewood Hospital, was honored after his death in 1954 with the naming of Graber Avenue.

Seville (Medina County)

Doctors A. P. Beach of Seville and J. D. Robinson of Wooster delivered the largest human baby on record here on January 19, 1879. Anna Swan Bates, being 7 ft 9 in tall, gave birth to a boy whose weight was 23¾ lb, its height was 30 in; it lived only 11 hours; a replica is at the Cleveland Health Museum. An exact duplicate of the "Home of the Giants" stands two miles east of Seville, on Acme Hill.

Tiffin (Seneca County)

In 1820 Josiah Hedges established a new settlement on the south side of the Sandusky River, opposite Oakley, and called it "Tiffin" in honor of Ohio's first governor, Edward Tiffin (1766-1829). Tiffin was a practicing physician from age 17 years to his death; he held public office for 31 years, one being Surveyor General of Ohio. He is not included in the "My Jewels" Monument in Columbus, but his friends erected a memorial shaft at Grandview Cemetery in Chillicothe.

Oxford (Butler County)

Miami University named a natatorium for John Shaw Billings (1838-1913), who entered that university at age 14 years; he was born just 50 miles southwest, in Vevay, Indiana, where there is a state historical marker.

Willoughby (Lake County)

The present township of Willoughby was formerly called "Chagrin," before that "Carlton." In 1834 Dr. Westel Willoughby, president of the Fairfield Medical College (N.Y.), was asked to give his name to the newly incorporated Willoughby University on Lake Erie and "Chagrin" was changed to Willoughby.

Wilmington (Clinton County)

A bronze tablet to the memory of George M. Austin, M.D., was put on the lawn of the Wilmington Public Library. Dr. George M. Austin, who died in 1930, was a prominent physician and geologist. He presented his fossil collection of 25,000 specimens to the National Museum in Washington, D.C.

Zane Township (Logan County)

A granite monument was unveiled on August 18, 1941 in a field bordering the East Liberty-Middleburg Pike in Zane Township close to the burial ground of Dr. Phoebe Haines Sharp. She came to Logan County in 1800; she was the first physician to practice there, also the founder of the first school and church; she was a member of the Society of Friends.

LET US TURN TO OHIO, which is treated in the opening chapter of Section III, the Middle West, and more or less as a stopover on the way from Pittsburgh to Chicago (Columbus) or from Buffalo to Chicago, where *Baedeker* suggests the traveler stop at Cleveland. This city rates about four pages: the Hollenden Hotel gets a star. The book mentions the three-cent fare of the electric tramways, records seven places of amusement, one of which offers "first class vaudeville"; two others have the by line "vaudeville and burlesque." No motion-picture houses are mentioned in this 1909 *Baedeker* on the United States.

Baedeker goes all out for Cincinnati, praises its location "finely situated on several terraces rising from the right (N) branch of the Ohio and surrounded by an amphitheater of hills 4-500 feet high." The book tells all about the district "Over the Rhine" and its inhabitants, becomes quite lyrical about Eden Park, which is starred, and the Art Museum; starred also are Spring Grove Cemetery and the zoo, which contains a fine collection of animals and is a favorite resort and restaurant; concerts are held there. The collection of Rookwood pottery is starred, and so is the suspension bridge across the Ohio River to Covington, Ky., built by John A. Roebling. A footnote "to the scientific traveler" says that Cincinnati is the most convenient locality from which to visit the famous Serpent Mound, which he describes in detail. —Bruno Gebhard, M.D., Cleveland: "The Doctor Travels with Karl Baedeker," *Bulletin of the New York Academy of Medicine*, 46:469-478, June 1970.

American Medical Historiography in the 19th Century

Genevieve Miller, Ph.D.*

TODAY THERE IS considerable interest in the history of medicine among both the professions dealing with the health sciences and lay members of the community. General historians now include aspects of the history of science, including medicine, in their works since they realize that matters of public health and disease are part of the history of a civilization. Is this interest new, or is it merely a continuation of past activity?

A survey of the medical literature of the 19th century reveals many publications relating to the history of medicine. These were usually orations presented before medical societies, or introductory lectures to the new medical school class. Throughout the century the notion of progress in human affairs was very strong, and almost without exception these historical accounts stressed this factor. In fact, David Ramsay's oration delivered on January 1, 1801 before the Medical Society of South Carolina was called a "Review of the Improvements, Progress and State of Medicine in the XVIIIth Century," and Josiah Bartlett's speech to the Massachusetts Medical Society in 1810 discussed the progress of medical science in Massachusetts. Occasionally there was a reactionary like David Hosack of New York, who delivered an introductory lecture in 1807 on ancient surgery in which he tried to show that many of the reputed discoveries of modern times had actually been made in antiquity. Anniversaries also evoked historical addresses, as they do today. One of the major contributions to American medical historiography of the 19th century was the series of essays called *A Century of American Medicine* published during the centennial celebration of the Declaration of Independence.[1]

In medical schools the introductory lecture presented at the first session of each school year was given by a leading member of the faculty and was attended by the lay public as well as by the students. Many were published, and today they afford a rich mine of material about the concerns of medicine and medical educators in the 19th century. The records of formal courses in medical history in the curriculum are meager. Probably the first was that given by Robley Dunglison from 1825 to 1833 at the instigation of Thomas Jefferson at the University of Virginia. Years later, in 1872, Dunglison's son published his father's lectures.[2] It is doubtful if there was much formal teaching for then, as now, time was a crucial factor. The curriculum consisted of two years of courses lasting no longer than four months each year, and the second year was usually a repetition of the first. Practical knowledge was acquired by students in association with a practicing physician. The medical school lectures formalized information they had previously acquired in observing a physician or by reading. One "read" medicine as one "read" law. In this "reading" however one acquired considerable familiarity with early authors extending back to Hippocrates and Galen. Two 19th century books which we would term "historical" today since they deal with ancient authors, ie, Elias Marks, *The Aphorisms of Hippocrates* (in Latin) *with a Literal Translation on the Opposite Page, and Explanatory Notes* (New York, 1817) and John Redman Coxe, *The Writings of Hippocrates and Galen, Epitomized from the Original Latin Translations* (Philadelphia, 1846), were published in order to make the writings of ancient physicians available for present-day professional use. They also served the additional function of making the works of ancient writers available in English. In the 19th century a well-educated person was expected to be able to read both Latin and Greek, but we know that few in America except clergymen ever achieved this. Most physicians had little more than a high school education.

In spite of deficiencies in formal education, many 19th century physicians became the leading

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natural scientists of the time. While they made their living practicing medicine, they made outstanding contributions to zoology, botany, ornithology, geology, paleontology, and anthropology because of their interest in the environment. In Ohio, Samuel P. Hildreth (1783-1863) and Jared Potter Kirtland (1793-1877) are two outstanding examples. A number of physicians were learned in classical languages and were influenced by contemporary scholarship in the humanities. In the midcentury, two books on ancient medicine were published, one in Cincinnati and the other in New York, by individuals who were well versed in classical and contemporary historical literature. They were T. L. Wright's *Disquisition on the Ancient History of Medicine* (Cincinnati, 1855) and John Watson's *The Medical Profession in Ancient Times* (New York, 1856). An excellent example of the scholar-physician was Henry E. Handerson of Cleveland who, in 1889, published *Outlines of the History of Medicine and the Medical Profession,* which was a translation of Hermann Baas' *Grundriss der Geschichte der Medicin* (Stuttgart, 1876) revised, and with an extensive section on the history of American medicine. This book was *the* textbook of medical history at the turn of the century, being finally superseded by Fielding H. Garrison's *Introduction to the History of Medicine* which appeared just before World War I.

Dr. Handerson was thoroughly trained in the classics, having obtained an MA degree at Hobart College in 1858. He studied medicine after the Civil War, during which he fought on the Confederate side and was imprisoned in a Union prison for the last two years. During this time, he sent home for copies of Greek and Latin texts from which he read and taught his fellow prisoners. After beginning practice in New York, he presented several extensive historical papers to the local medical society and published a lengthy article on the *School of Salernum, an Historical Sketch of Medieval Medicine* (New York, 1883). This work reflects painstaking scholarship and a sophisticated approach to source material. After his wife died in childbirth and three of this four children succumbed to diphtheria within two years, Handerson returned to Cleveland where he had grown up. He was one of the founders of the Cleveland Medical Library Association in 1894; his historical medical library forms the nucleus of the rare book collections of the Allen Memorial Medical Library. Many volumes contain elaborate notations or handwritten indices. Because Handerson never wrote a textbook of medical history of his own and his other publications were not numerous, he was soon forgotten. Therefore, it was appropriate that a new medical history society formed in Cleveland in 1953 was named the Handerson Medical History Society in order to preserve the memory of and appreciation for his achievements.

On a national level, John Shaw Billings is the best example of the scholar-physician who contributed to medical history. After the Civil War ended, Billings was assigned to the Library of the Surgeon General's Office which he built into the major medical library of the country, today the National Library of Medicine in Bethesda, Maryland. He collected not only current medical books but thousands of works of the past also. Realizing the urgency of bibliographic aids to gain access to material, in the 1870's he initiated the *Index-Catalogue of the Surgeon General's Library* and *Index Medicus.* His lengthy chapter on the "History and Literature of Surgery" in Dennis and Billings, *System of Surgery* (Philadelphia, 1895) is his major written contribution to medical history.

Medical history of another sort was a by-product of major crises in American history such as war. Histories of all our wars were written by physicians, beginning with surgeon James Mann's *Medical Sketches of the Campaigns of 1812, 13, 14,* published in Dedham, Massachusetts in 1816 and seven years later, Dr. James Thacher, also of Massachusetts, published his *Military Journal During the American Revolutionary War* (Boston, 1823). These were regarded as being of possible value for the future since they discussed medical problems to be solved as well as the nature of diseases and injuries incurred under war conditions. The tradition continued with the six-volume *Medical and Surgical History of the War of the Rebellion* issued by the Surgeon General's Office from 1870 to 1888.

Following European examples, the compilation of medical biographies also occupied the attention of 19th century American physicians, beginning with James Thacher's two-volume *American Medical Biography* in 1828, which contained 163 biographical accounts. This was continued in 1845 by Stephen W. Williams' compilation of the same title, ie, *American Medical Biography: or, Memoirs of Eminent Physicians, Embracing Principally Those Who Have Died Since the Publication of Dr. Thacher's Work,* which added 109 additional sketches. Samuel D. Gross' *Lives of Eminent American Physicians and Surgeons of the Nineteenth Century,* which appeared in Philadelphia in 1861, was not a comprehensive biographical dictionary as the title might suggest, since it includes only 32 biographies. However, they are much more detailed than in Thacher or Williams. The Washington, D.C. physician, Joseph M. Toner, followed a biographical arrangement in his *Medical Men of the Revolution,* published in Philadelphia in 1876.

Many of the local state and county medical histories, which began to appear about this time, were essentially compilations of biographical sketches. The Toner Collection at the Library of Congress is one of the richest sources for 19th century material, since he saved all sorts of ephemera such as pamphlets, medical school catalogues, and local publications.

We have already noted that, with the exception of the Dunglison lectures at the University of Virginia in the 1820's, medical education was not concerned with historical matters. In 1876 John Shaw Billings accepted an appointment as lecturer in the history of medicine at the newly created Johns Hopkins University, giving the following year a series of 20 lectures on medical history, legislation, and education. Sixteen years later, in 1893, the Johns Hopkins Medical School opened its doors and he was appointed lecturer in the history and literature of medicine. The opening of the Johns Hopkins University and Medical School was a landmark in American education in both the humanities and sciences. This new institution was planned to set an example to the rest of the country to demonstrate how advanced education and research were to be taught. Based on European, and particularly German models, the new school went even further than its prototypes in introducing medical history into the curriculum, for it was just in this time that academic medical history reached its lowest level in Europe as a result of the spectacular success of the new experimental scientific medicine, which made history seem useless to medical scientists and practitioners. Billings and his associates at Johns Hopkins, including William H. Welch, William Osler, and Howard A. Kelly, who founded the Johns Hopkins Hospital Historical Club in 1890, were all convinced that knowledge of history made a physician a more complete man. As Henry E. Sigerist wrote: "They were medical humanists who were conscious of the point in the historical development at which they stood. Their teaching was scientific but imbued with humane and historical considerations, and today still you may recognize their students by their broader culture."[3] They were also book collectors, and many of the major historical collections in the United States and Canada were made by them and their students.[4]

By the end of the century several medical schools had begun to give courses, for example, the University of Buffalo, where Roswell Park lectured, and Western Reserve Medical School with Henry Handerson. Papers read at the Johns Hopkins Hospital Historical Club were published in the *Johns Hopkins Hospital Bulletin* and appear to have exerted considerable influence throughout the country. The first "professorship" in the subject did not come until 1903 when Eugene Cordell of Baltimore, the librarian at the University of Maryland Medical School, was given the honorary title of Professor of the History of Medicine. Thus we see that in the 19th century there were many distinguished predecessors who paved the way for our current activities in the history of medicine.

References

1. Clarke EH (ed): *A Century of American Medicine 1776-1876.* Philadelphia, 1876.
2. Dunglison RJ (ed): *History of Medicine From the Earliest Ages to the Commencement of the Nineteenth Century.* Philadelphia, Lindsay & Blakiston, 1872.
3. Sigerist HE: Medical history in the United States; past-present-future; a valedictory address. *Bull Hist Med* 22:47-64, 1948.
4. Osler Library at McGill University; Harvey Cushing, Arnold Klebs, and John F Fulton Libraries which came together at Yale University; WS Halstead, HA Kelly, and Henry Barton Jacobs Collections at Johns Hopkins University.

Discussion of E.N.T. Case of the Month

(continued from p. 773)

Any patient with the history of persistent hoarseness lasting for more than two weeks should have a complete examination of his larynx to rule out the possibility of carcinoma. The "gaggy patient" may be examined in this sequence. First, topical anesthetics may be tried, *but remember they are toxic.* If you use them be sure to have the necessary measures on hand to treat any reactions that may occur. If topical anesthesia alone fails, the patient may become cooperative with sedation. Intramuscular Demerol and Seconal coupled with topical anesthetics may render an extremely gaggy patient quite easy to examine. On occasion, intravenous Valium has been found to be useful. However, a few patients with a severe gag reflex will fail to become cooperative despite any of the methods described. If the hoarseness is persistent, general anesthesia may be required for a complete examination of the larynx.

Direct laryngoscopy was necessary in the patient described. Upon viewing his vocal cords, a white, raised lesion was seen involving the middle one third of his left true cord (Fig. 1). Excisional biopsy was done, revealing invasive squamous cell carcinoma.

Carcinomas arising here usually have an excellent prognosis for two reasons. First, because they give an early symptom (hoarseness), diagnosis can be made when the tumor is very small. Second, the true vocal cord has poor lymphatic drainage, making neck metastasis uncommon. Either radiation therapy or conservation surgery, both of which preserve vocal function, will give excellent results.

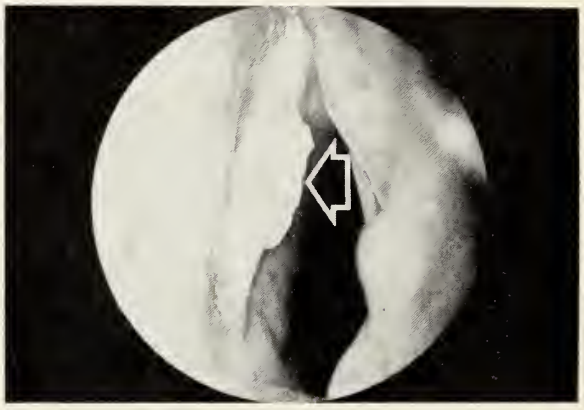


FIG. 1. This white raised area proved to be an early squamous cell carcinoma.

However, if these cancers remain undiagnosed (laryngoscopy is not done), the tumor will extend into the rich lymphatic bearing portions of the adjacent larynx. The patient will then require more extensive surgery (usually a total laryngectomy) with a decreased chance of obtaining a cure.

Any patient with hoarseness lasting over three weeks should have complete visualization of his larynx.

Generic and Trade Names of Drugs

Meperidine hydrochloride — Demerol (Winthrop Laboratories)
Sodium secobarbital — Seconal (Eli Lilly and Co.)
Diazepam — Valium (Roche Laboratories)

Professional Activities



AMA San Francisco Convention

Report on Ohio Resolutions Introduced in AMA House of Delegates and Actions Taken

THE OHIO DELEGATION to the American Medical Association introduced nine resolutions at the 121st AMA Annual Convention in San Francisco June 18-22. Seven of the resolutions were introduced as a result of action taken by the OSMA House of Delegates and two were introduced at the direction of The Council.

One Ohio resolution calling for representation of private practicing physicians on the special committee appointed by the President to advise on Phase II pronouncements dealing with medical costs, was withdrawn. The Delegation was informed that two physicians in private practice are members of this committee.

The Ohio Delegation was successful in getting a resolution passed which called for the preservation of the American Medical Association as a "federation" of medical associations of states, commonwealths, territories or insular possessions. It was resolved that representation in the House shall continue to be by proportionate representation of the above mentioned groups and that any section, service, or other group specifically designated by the House of Delegates shall be on the basis of one delegate and one alternate delegate.

There were other resolutions on this subject which, if passed, would have provided for proportionate representation in the House for specialty societies and representation for the American Hospital Association and the American Association of Medical Colleges.

One of the resolutions introduced by Ohio would have had the AMA to handle emergency resolutions in the same manner as approved by the OSMA House at its 1972 Annual Meeting. This resolution was "filed" for possible future consideration.

Several resolutions, including one from Ohio on the subject of certification and subcertification in nuclear medicine, were considered by the delegates. The policy, as adopted by the House, states in part:

"The American Board of Nuclear Medicine, a conjoint board, can issue a general certificate in the field of practice represented by the conjoint board, and its sponsoring primary boards may issue special certificates in the related limited fields of their particular interest. . ."

Authorization was given to the American Board of Radiology to issue certificates in diagnostic radiology, with special competence in nuclear radiology. The American Board of Pathology was given similar authorization to issue certificates of special competence in radioisotopic pathology.

The intent of the Ohio resolution, calling for recognition of nonmedical facilities for rehabilitation and followup care in the successful treatment programs for alcoholism, was incorporated in another resolution on the subject of alcoholism.

Another Ohio resolution urging the AMA to bring to the attention of the American public deficiencies in the Medicare and Medicaid programs was referred to the Board of Trustees with the

comment that this has been a continuing activity of the Association since the institution of these programs.

There was considerable and lively debate on the Ohio resolution calling for mandatory jail sentences for those found guilty of committing or threatening to commit a misdemeanor involving the use of a firearm. A substitute resolution was adopted in lieu of the Ohio resolution calling on the AMA to express its strong abhorrence and continued opposition to the use of a firearm, or any weapon, in the commission of a crime and that it urge the enforcement of strict penalties for such use.

The AMA House of Delegates approved the Ohio resolution urging the AMA to strongly voice its opposition to the government formalization of medical care regionalization as a "mission" of the Regional Medical Programs. It was the reference committee's opinion that reemphasis should be given to the AMA policy that the RMP should fulfill its original purpose of education and not become involved in funding actual delivery and service programs.

Nontherapeutic use of pharmacological agents by athletes was the subject of another Ohio resolution, which was amended and approved by the House of Delegates. The resolution urged rigid control of prescription of stimulant and sedative drugs and androgenic-anabolic steroids to athletes or to those who might put such agents into the hands of athletes. The sentiment of the House was that this policy should in no way be construed as limiting a physician's proper use of drugs in the indicated treatment of athletic injuries or clinical symptoms of individual athletes.

For additional information on the AMA House of Delegates actions and other Convention activities, please refer to recent issues of the *American Medical News*.

Continuing Education Opportunities for Physicians in Ohio

August

Third Annual Short Course on Laser Safety —Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, at the University, August 7-11; tuition, $325. Contact course director, Mr. R. James Rockwell, Jr., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229.

Annual Scientific Assembly, Ohio Academy of Family Physicians—Sheraton-Columbus Hotel, downtown Columbus, August 8-10.

September

Infections in Obstetrics and Gynecology — Sponsored by the Cleveland Society of Obstetricians and Gynecologists in the Bunts Auditorium of the Cleveland Clinic, 3:00 p.m., September 13; William Ledger, M.D., of the University of Michigan, guest speaker; contact Kathryn Hoffman, M.D., 806 Rose Building, Cleveland 44115.

October

Pediatric Postgraduate Conference, Ohio State University College of Medicine, October 4-5.

Group Psychotherapy, Ohio State University, October 6 through December 22 (26 hours).

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Chronic Otitis Media in Children, Ohio State University College of Medicine, October 7.

Annual Cancer Symposium sponsored by the American Cancer Society, at Scot's Inn Motel, Columbus, October 11, 9:00 a.m. to 4:00 p.m. Contact, American Cancer Society, Ohio Division, 1367 East Sixth Street, Cleveland 44114.

Diabetes Seminar, Ohio State University College of Medicine, October 25.

Current Therapy III — Infectious Diseases — Third Annual Postgraduate Medical Seminar sponsored by the Scioto County Medical Society; Thursday, October 26, at the American Legion Hall, 705 Court Street, Portsmouth.

Psychotherapy of Adolescents, Ohio State University College of Medicine, October 27-28.

It's about time somebody told the true story of the American Doctor.

You'd agree 100% on that. There have been too many of the other kind of story.

You know that the vast majority of American doctors are honest, hardworking, skilled and dedicated human beings who have the interests of their patients at heart.

That's exactly what the AMA is trying to make the public aware of.

One of the many ways the AMA is doing it is through its special communications program.

Perhaps you've seen pages in newspapers and national magazines signed "America's Doctors of Medicine." They're part of this program. It tells the true story of what it takes to become a doctor. The ways American medicine has improved the public's health. And to express the profession's concern about health by providing information which will help every American lead a healthier life.

We're telling this story for you, the American doctor. If we are to continue to represent you effectively, we need your support.

Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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WE CAN DO MUCH MORE TOGETHER.

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If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four month Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.
Indicates estrogen excess.
1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.
Indicates androgenic excess or estrogen deficiency (fertility is suspect).
1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.
Indicates probable buildup of progestogen-related side effects.
1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.
Indicates metabolic production of androgen or relative estrogen deficiency.
1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

ge 25, tall, slender, athletic,
ith flat chest. On a progestogen-
ominant 50-mcg.-estrogen O.C.
as recurrent trichomoniasis
nd Monilia.
Indicates estrogen deficiency and
cess of progestogen in current O.C.
1st choice: Switch to a com-
nation pill with 100 mcg.
strogen and less progestational
tivity (such as **Enovid-E*** or
vulen* or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.
Indicates probable need for more estrogen.
1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.
Indicates probable progestogen excess.
1st choice: Switch to a center-spectrum pill (such as **Ovulen***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has pre-menstrual fluid retention and leg cramps.
Indicates probable excess of estrogen.
1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen***).



Ovulen® a balanced center-spectrum O.C. for most

Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen® a moderately progestogen-dominant O.C. for many

Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

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Enovid-E® a moderately estrogen-dominant O.C. for some

Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

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prescribing information,
lease see next page.

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Actions – Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Ovulen and Demulen are indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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The *Special Note*, *Contraindications*, *Warnings*, *Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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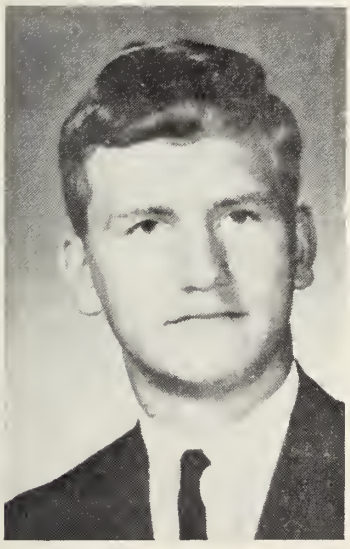
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Cloverdale, Maple Heights Residents Receive OSMA Family Practice Scholarships

TWO OHIO RESIDENTS, Carl S. Wehri, of near Cloverdale in Northwestern Ohio, and Mrs. Phyllis Anne Hutson, of Maple Heights, are recipients of OSMA's 1972 Family Practice Scholarships of $2,000 each. They were selected from among 38 candidates who will enter medical school during this summer and fall.

Dr. William R. Schultz, Wooster, OSMA President, said this year marked the 24th annual awarding of the scholarships. Candidates are judged on the basis of character, integrity, intelligence, mature personality, interest in community affairs, need, leadership and scholastic ability.



Carl S. Wehri

Mr. Wehri, 22, was graduated from Kalida High School in 1968. He recently completed his premedical studies at Ohio State University, and entered the OSU College of Medicine in July. In his letter of application, Mr. Wehri explained that he has wanted to be a family physician in a rural area since his sophomore year in high school, and that he plans to begin general practice in Ohio following his medical training.

Mrs. Hutson, 24, a graduate of Maple Heights High School, took her premedical training at Pembroke College, Brown University, Providence, Rhode Island, and Case Western Reserve University. She will enter Case Western Reserve University School of Medicine this fall. Mrs. Hutson explained in her letter of application that it is important that some physicians function as family physicians in order to combat the increasing impersonalization in medicine. She added that with a family physician the patient knows where to go at the first sign of illness and, therefore, doesn't have to diagnose the illness himself in order to choose a specialist to visit.

Mr. Wehri and Mrs. Hutson are among seven students in medical school who have received OSMA scholarships. Included are Richard W. Pine, Columbiana (Case Western Reserve University School of Medicine); John E. Pappas, Cuyahoga Falls (Temple University School of Medicine, Philadelphia); John H. Surry, Youngstown (St. Louis University School of Medicine); Donald M. Miller, Upper Sandusky (Medical College of Ohio at Toledo), and Albert J. Weisbrot, Cincinnati (University of Cincinnati College of Medicine).



Phyllis Anne Hutson

The following recipients of OSMA Family Practice Scholarships recently received their MD degrees: Mrs. Rebecca Terrell Strafford, New Vienna (Ohio State University College of Medicine—residency at Indiana University Medical Center, Indianapolis); Larry R. Thomas, Findlay (Ohio State University College of Medicine—internship at University of Oregon Medical Center), and Paul R. Garrett, East Palestine (Medical College of Ohio at Toledo—internship at Grady Memorial Hospital, Atlanta, Georgia.

Physician Participation in the Decision-Making Function of Selected Ohio Hospitals

By Edgar O. Mansfield, Dr. P.H.
Administrator, Riverside Methodist Hospital, Columbus

I. PHYSICIANS ON HOSPITAL BOARDS OF TRUSTEES

IN RECENT YEARS national, state and local medical associations and societies have taken strong positions for physician representation on boards of trustees of United States hospitals. The Joint Commission on Accreditation of Hospitals has included in its standards a fairly clear-cut sanction and even encouragement for physician membership on hospital boards. The real goal, perhaps, is physician participation in the decision making process in hospitals. This goal could be achieved in several basic ways:

1. Physician membership on boards of trustees

2. Through the Joint Conference Committee

3. Substantive, on-going participation by physicians in the executive administration of hospitals (hospital committees, medical staff committees, and other medical liaison).

This paper will examine the matter of physician participation in decision making in hospitals as it appeared to stand at mid-1971, based upon 87 responses from administrators in Ohio. The survey is a cross section of a segment of a larger national survey that was based upon almost 200 responses (out of 250 surveys) from administrators across the country. The national survey covered not-for-profit hospitals of many types and sizes in 33 states (university hospitals, mental and other specialty hospitals, and certain other hospitals known to have "advisory type" boards were excluded). A breakdown of the responding hospitals in Ohio by bed size follows:

Bed Size of Hospitals	Number of Hospitals Responding
Under 100 beds	11
100-249 beds	40
250-399 beds	17
400 beds or over	19
Total	87

Physicians Serving on Respondent Hospital Boards

Almost two-thirds (62.1 percent) of the surveyed hospitals had physicians on their boards. Only in hospitals of 100 beds or less was the percentage under 50 percent.

Bed Size of Hospitals	Total Hospitals Responding	Physicians On Board	Do Not Have Physicians On Board
Under 100 beds	11	4	7
100-249 beds	40	25	15
250-399 beds	17	14	3
Over 400 beds	19	11	8
Totals	87	54	33

How Many Physicians on Board

A basic question was, "How many physicians are on the board?" Here are the answers:

No. of Physicians On Board	No. of Hospitals
1	25
2	17
3	5
4	6
5	0
6	1
7 or more	0

From the viewpoint of percentages of physicians to total board:

Physicians comprised:
less than 5% of the total board in 5 hospitals (9.3%)
5%-14% of the total board in 34 hospitals (63%)
15%-24% of the total board in 13 hospitals (24.1%)
25%-34% of the total board in 1 hospital (1.8%)
35% or greater of the total board in 1 hospital (1.8%)

How Long Physicians Have Been on Boards

To the question, "How long have you had physicians on your board?":

3 hospitals (5.5%) said less than one year
22 hospitals (41%) said one to four years
12 hospitals (22%) said five to ten years
17 hospitals (31.5%) said over ten years.

It is interesting to find that 29 respondent hospitals, or 53.7 percent of the total that have physician trustees, have had them five years or longer. Even more significant and perhaps not a little surprising is the fact that almost one out of three responding hospitals have had physicians on their boards for over ten years.

Twenty-five hospitals (46.3 percent) have taken action in the past four years to place physicians on their boards. It would appear that the position taken by the American Medical Association (and state and local medical societies) has been quite effective. This has been achieved despite the long-standing admonitions and text book positions of two outstanding writers, Malcolm T. MacEachern, M.D. and Charles U. Letourneau, M.D., both of whom have had considerable influence on the thinking of administrators and boards. Letourneau slightly softened his position in his recent book, "Hospital Trusteeship," but MacEachern, one of the all time greats of hospital organization and standardization, opposed physician membership till his death.

Methods of Selection of Physician Trustees

"How are physicians selected for membership on the board?"

A total of 57.6 percent of the physicians are elected in the same manner as other members of the board of trustees.

Another 35.6 percent of the physicians are elected by the medical staff.

It is presumed that in the preceding 35.6 percent, the hospital boards may well have a provision in their constitutions and bylaws which places one or more physicians on the board who are elected by the staff to either, (a) physician slots on the board (whether or not these physicians are officers of the medical staff); or, (b) official medical staff positions (i.e., president, chairman chief, etc.). In either situation, election by the medical staff constitutes election to the board of trustees.

It is in like manner assumed in the 57.6 percent, the regular channel for nomination (i.e., nominating committee, governmental official, church official or other designated persons or group) and then formal election to the board of trustees is used.

The method of selection of physicians to hospital boards may well have something to do with their attitude, work and effectiveness as hospital trustees. More will be said of this in the summary.

Term of Office of Physician Trustees—Privileges

Of those who responded, 37 percent stated that the term of office of physician trustees coincided with their terms as officers of the medical staff.

A total of 70.3 percent stated that the term for physician trustees was the same as that for all other members of the board.

Of the respondents, 88.8 percent stated that the physician members of the board had discussion, participation, voting and committee membership privileges. About 68.5 percent stated that physicians could be officers of the board. Interpretation of the survey form might lead us to wonder whether this latter (68.5 percent) figure was a matter of practice rather than of privilege.

Participation in Board of Trustees Work

A total of 94.7 percent of the respondents felt that attendance of physicians at board meetings was good or excellent. This is an unusually fine response and indicates the serious interest that physicians seem to have in the work of the board.

Here are some other evidences of physician participation as seen by hospital administrators:

	Hospitals	Percentages
Participates only in staff related matters	9	16.6
Has tendency to lobby or politic	8	15
Has broad effective participation	41	76
Relates well to board	51	95

How Physician Membership on Hospital Boards Is Viewed By:

	Pleased		Apathetic		Displeased	
	No.	%	No.	%	No.	%
Medical Staff	34	65.4	4	7.6	14*	27
Board of Trustees	47	85.4	4	7.3	4	7.3
Administration	49	93.0	1	2.0	3	5.0

(*Displeased in the sense that the medical staff presses for additional staff members on board.)

These figures indicate that a very high pro-

portion of trustees and administrators having physician members on their boards are pleased.

Can Physicians Serve on Hospital Boards as Effective Community Representatives as Contrasted to Direct Political Representatives of the Medical Staff?

	Number Respondents	Percentage
Yes	44	80
No	11	20

An apparently loaded, multiple-answer question was included at the end of this section of the survey form, and the responses elicited have a tendency to raise a few questions about the otherwise heavy preponderance of administrators in favor of physicians serving on hospital boards. Here is the question just as it was asked on the survey:

"Please check any or all of the points below that you feel are valid in opposing physician memberships on hospital boards:"

	Number of Administrators Checking
Medical Staff pressure upon Board	11
Conflict of interest	24
Opens door to other special interest groups desiring board membership	10
Joint Conference Committee is better method of liaison and action	16
Present system is effective	7
Let sleeping dogs lie	1

The fact that hospital administrators who are pleased with and speak well of having physicians on their boards feel that there are valid reasons, as shown above, to oppose physician membership on hospital boards may well indicate that the seeming anachronisms of MacEachern, Letourneau and others are still fairly deep-seated.

II. THE JOINT CONFERENCE COMMITTEE — AN ALTERNATE METHOD FOR PHYSICIAN INPUT AT BOARD LEVEL

Hospitals Having Joint Conference Committees

Almost 88 percent of the hospitals surveyed have joint conference committees. Over half of these (59 percent) were said to be moderately active and 27 percent stated that their joint conference committees were very active. Only 13 percent were inactive according to the survey. This data tends to counter the frequently heard notion that most joint conference committees are not active committees, and indicates reasonably good activity levels for almost 88 percent of the joint conference committees.

Sixty-seven and six-tenths percent of the respondents stated that the joint conference committees were not "crisis" oriented. Thirty-two and four-tenths percent indicated that the joint conference committee was "crisis" oriented at their hospitals. This is a reasonably high percentage of hospitals in which the committee meets, apparently only to handle urgent or perhaps emergent problems.

Initiating Agenda Items

Agenda items for joint conference committee meetings seem to be initiated by medical staff members of the committee equally with board and Administration members. This evidences good balance and may mean that physician members feel free to bring out and discuss their primary staff problems at this level in the organization. If this assumption is correct, there may well be more time for medical staff advocacy of their own positions, a smaller and possibly more receptive board of trustee audience, and generally a quite satisfactory atmosphere for discussion (and ultimate recommendation) than would be found at most, or at least many, board of trustee meetings.

Attendance

Attendance of medical staff and trustee members of the joint conference committees is quite good as the following survey figures show:

	Attendance		
	Good	Fair	Poor
Medical staff members	60	12	2
Board of trustee members	63	10	1

How Joint Conference Committees Are Regarded

In answer to questions relating to the way the medical staff and the board of trustees regard the joint conference committee, the following data was given:

	How Joint Conference Committee is Regarded		
	Effective	Cum Si Cum Sa	Not Effective
By Medical Staff	36	35	2
By Board of Trustees	41	31	1

These figures, obviously, do not identify a strong, highly regarded committee in roughly half of the hospitals surveyed. About 69.8 percent stated

that the medical staff at their hospitals were somewhat apathetic or negative concerning the joint conference committee. The board of trustees are reported to feel that it is an effective mechanism in almost 56 percent of the respondent hospitals. This leaves much to be desired for the joint conference committees in the eyes of both medical staff and board. Administrators' personal views of the committees register almost the same as those of trustees.

One might, with a little conjecture and fancy guesswork, assume that in hospitals where the joint conference committee is the principal means of liaison, input and participation of physicians in the decision making processes of the hospital, it works reasonably well.

III. OTHER METHODS OF PHYSICIAN PARTICIPATION

Hospital and Medical Staff Committee Participation

Participation of physicians on hospital and board committees seems to be quite generally accepted. The following committees in order of physician participation are listed:

Committee	Number which Include Physicians
Long Range Planning Committee	62
Executive Committee	28
Finance Committee	10
Personnel Committee	13
Purchasing Committee	16
Administration Committee	12

Administrators stated that physicians took a very active part in the deliberations and actions of the committees. It is of some significance to find that the long range planning committee and the executive committee contain physicians from two to four times as often as do the other hospital committees. It would appear that the physician input and participation in the decision making function of hospitals is quite heavily felt at committee level.

The matter of medical staff committees as a source of input to the decision making processes was probed with the following question: "What roles do the existing medical staff committees play in the decision making processes?" Here are the answers provided by respondent hospital administrators:

Little or no role	5
Purely advisory	37
Strong role in determining decisions	41
Committee decisions are final	4

Almost 52 percent said that medical staff committees play a strong role in determining decisions in their organizations. Almost 43 percent felt that such committees were purely advisory. It might perhaps be assumed that the advice of medical staff committees could be important advice, often strong enough to influence the final decisions made in hospitals. The survey figures appear to tell us that the existing medical staff committees play a real heavy part in decision making processes in hospitals today.

Other direct participation of physicians, according to survey responses are:

1. Participation on formulating hospital expense budget:
   Yes — 20 No — 66
2. Participation in program or project budgeting:
   Yes — 38 No — 46

IV. SUMMARY

There seems to be a steady growth in numbers of hospitals that have physician representation on hospital boards. The survey shows out of the 54 hospitals having physicians on boards (Approximately 62 percent of total surveyed) 25 (or almost 47 percent) have adopted this plan within the past four years. Of these hospitals 77.7 percent had either one or two physicians on their boards, indicating that the actual number of physicians involved is growing at a lesser pace.

One of the key elements in this system appears to be the method of selection of physician members to hospital boards of trustees. The survey shows that almost twice as many physician trustees are elected in the same way as other trustee members as are elected by the medical staff. This would seem to be the preferable method as it could accomplish, among other things, the following:

1. The same length of term as other trustees.
2. Comparable authority, responsibility and status with other trustees.
3. Maximum freedom to carry out the bona fide purposes of trusteeship without being beholden to any single group.
4. Greatest breadth of representation.

A major attitudinal finding of the study is the matter of the apparent attitude of hospital

administrators surveyed towards physician membership on hospital boards. All direct questions indicate a heavy preponderance of favorable responses to having physicians serve as members of hospital boards. Administrators are pleased with the idea, feel it works very well, and have a very high regard for the attendance, participation and results of physicians on boards. They are, on the other hand, seemingly of the opinion that medical staff pressure, conflict of interest, breaking of precedent concerning specialty groups on boards, use of joint conference committee and an effective present system are valid possible reasons for opposing physician membership on hospital boards.

It was pointed out in a number of narrative responses that with regard to physician effectiveness on boards much depends upon the caliber and quality of the individual physician(s) involved. This truism applies equally to all trustees.

The joint conference committee in over half of the respondent hospitals does not seem to be a strong solid mechanism highly regarded by the medical staff to do its job. Boards and administrators view the effectiveness of these committees slightly higher than do the medical staffs.

Hospital and medical staff committees are definitely very effective in providing medical staff accessibility to the management decision making function.

It is reasonable to conclude from the study that the three pertinent groups, (boards of trustees, medical staff members and hospital administrators) desire, and are working in a steady, proper way to increase vital physician participation and contribution to the decision making processes in the hospitals across the country.

Ohio State Confers Honors as 153 Graduate as M.D.'s

Thirty-four students who received doctor of medicine degrees from Ohio State University have been recognized for excellence.

They were honored at the College of Medicines's convocation, June 8, for the graduating class of 153. The physicians received their degrees at Ohio State's commencement June 9.

The class presented awards to six faculty members and to Dr. Richard L. Meiling, vice-president for medical affairs, who was recognized for his contributions to the college. Dr. Thomas Skillman, professor and director of the division of endocrinology and metabolism, was selected as "Man of the Year" and made an honorary member of the class.

The class chose to honor five other faculty members in addition to the traditional "Man of the Year" award. They are: Dr. Jack Geer, chairman of pathology; Dr. Albert S. Klainer, associate professor of medicine; Dr. Ralph Haynes, associate professor of pediatrics; Dr. Charles Bush, clinical instructor and chief resident of medicine, and Dr. Victor R. Ver Meulen, assistant professor of otolaryngology.

In addition, the class named its fund in memory of Dr. Grant O. Graves, former professor and chairman of anatomy, who died in February.

Three of those who received their doctor of medicine degrees were graduated summa cum laude, and an additional 13 cum laude. They were among the 34 students who received department awards, the Dean's award, and various other honors.

Ohio Specialty Organizations

FOLLOWING IS A ROSTER of Ohio Specialty Societies, with the names and addresses of presidents, secretaries, and in some instances program chairmen, brought to the attention of *The Journal* before this issue went to press. Some of these organizations meet and present programs during the OSMA Annual Meeting. Others hold programs at other times of the year. Every effort has been made to bring this roster up to date for the 1972-1973 season. The editorial staff will be glad to supplement this information at any time.

Ohio Academy of Family Physicians — President: Lauren M. Brown, M.D., 3515 Manchester, Akron 44319; Executive Secretary: Mrs. Florence I. Landis, 4075 North High Street, Columbus 43214.

Ohio Chapter, American College of Chest Physicians — President: Richard A. Krumholz, M.D., Kettering Memorial Hospital, 3535 Southern Boulevard, Kettering 45429; Secretary-Treasurer: Barney Wisinger, M.D., 2500 West Central, Toledo 43606.

Ohio Ear, Nose and Throat Society — President: Andrew W. Miglets, Jr., M.D., 320 West 10th Avenue, Columbus 43210 (Also Chairman, Section on E.N.T.); Secretary: William J. Loeb, M.D., 11811 Shaker Blvd., Cleveland 44120 (Also Secretary, Section on E.N.T.).

Ohio Society of Internal Medicine — President: William A. Millhon, M.D., 3600 Olentangy River Rd., Bldg. A, Columbus 43214; Secretary-Treasurer: William G. Cassel, M.D., 1909 Salem Avenue, Dayton 45406; Annual Meeting Committee Chairman: Donald G. Vidt, M.D., 2020 East 93rd Street, Cleveland 44106 (Also Secretary, Section on Internal Medicine).

Ohio Neurosurgical Society — President: David B. Roth, M.D., 146 Wyoming Street, Dayton 45409 (Also Chairman, Section on Neurological Surgery); Secretary: Philip L. Gildenberg, M.D., Cleveland Clinic Found., Cleveland 44106 (Also Secretary, Section on Neurological Surgery); Program Chairman: David Yashon, M.D., 410 West 10th Avenue, Columbus 43210 (Also Program Chairman, Section on Neurological Surgery).

Ohio Ophthalmological Society — President: Paul E. Ruth, M.D., 510 Dollar Bank Building, Youngstown 44503; Secretary: Robert H. Magnuson, M.D., 150 East Broad Street, Columbus 43215.

Ohio Orthopaedic Society — President: Clarence Hullinger, M.D., 8 West Main Street, Springfield 45502 (Also Chairman, Section on Orthopaedic Surgery); Secretary: John B. Roberts, M.D., 410 W. 10th Avenue, Columbus 43210 (Also Secretary, Section on Orthopaedic Surgery).

Ohio Society of Pathologists — President: Daniel Hanson, M.D., Mercy Hospital, 2221 Madison Avenue, Toledo 43624 (Also Chairman, Section on Pathology); Secretary: Robert G. Thomas, M.D., Dept. of Laboratories, Elyria Memorial Hospital, Elyria 44035 (Also Secretary, Section on Pathology); Program Chairman: George C. Hoffman, M.D., Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland 44106 (Also Program Chairman, Section on Pathology).

Ohio Chapter, American Academy of Pediatrics — President: Charles Q. McClelland, M.D., Rainbow Babies and Children's Hospital, 2101 Adelbert Road, Cleveland 44106 (Also Chairman, Section on Pediatrics); Secretary: George Smith, M.D., 908 Fountain Avenue, Springfield 45504 (Also Secretary, Section on Pediatrics).

Ohio Society of Physical Medicine and Rehabilitation — President: John L. Melvin, M.D., University Hospitals, 410 W. 10th Avenue, Columbus 43210 (Also Chairman, Section on Physical Medicine and Rehabilitation); Secretary: Nicholas

S. Checkles, M.D., University Hospitals, 1030 Dodd Hall, 472 W. 8th Avenue, Columbus 43210 (Also Secretary, Section on Physical Medicine and Rehabilitation); Program Chairman: Ian C. MacLean, M.D., University Hospitals, 410 W. 10th Avenue, Columbus 43210 (Also Program Chairman, Section on Physical Medicine and Rehabilitation).

Ohio Psychiatric Association — President: L. E. Whitmire, M.D., 3450 West Central Avenue, Toledo 43606 (Also Chairman, Section on Psychiatry and Neurology); Executive Secretary: Mr. Gene P. King, 88 East Broad Street, Columbus 43215; Program Chairman: Robert E. Walden, M.D., Medical College of Ohio, P.O. Box 6190, Toledo 43614 (Also Program Chairman, Section on Psychiatry and Neurology).

Ohio State Radiological Society — President: Joseph H. Hanson, M.D., 1544 S. Byrne Road, Toledo 43614; Secretary: Thomas F. Ulrich, M.D., 400 W. Tuscarawas Avenue, Barberton 44203; Program Chairman: Tearle L. Meyer, M.D., 175 S. Merkle Road, Columbus 43209.

Ohio Committee on Trauma, American College of Surgeons — Chairman: Robert C. Waltz, M.D., 25100 Euclid Avenue, Cleveland 44117; Secretary: Robert Zollinger, Jr., M.D., 2065 Adelbert Road, Cleveland 44106.

Ohio Rheumatism Society — President: Vol K. Philips, M.D., 1211 Dublin Road, Columbus 43215 (Also Chairman, Section on Rheumatic Diseases); Secretary: Joseph Levinson, M.D., University of Cincinnati Medical Center, 2825 Burnet Avenue, Cincinnati 45219 (Also Secretary, Section on Rheumatic Diseases).

Ohio State Society of Thoracic Surgeons — President: Gene Ewy, M.D., 931 Chatham Lane, Columbus 43221; Secretary: Patrick J. Moore, M.D., 931 Chatham Lane, Columbus 43221.

MDs in the News

Dr. Harry Wain, of Mansfield, Richland County health commissioner, was installed as president of the Ohio Public Health Association at the recent Cleveland meeting.

Dr. Warren G. Harding II retired July 1 as administrator of Grant Hospital, Columbus, a post he has held for seven years. He will retain his association with the hospital in an advisory capacity and as chairman of the board of governors of the Grant Hospital Education and Research Foundation. Donald H. Ayers, formerly associate administrator of Riverside Methodist Hospital, Columbus, has been named to the administrative post.

Dr. Joseph J. Bartolomeo, of West Richfield, has been appointed by Governor John J. Gilligan to the State Board of Nursing Education and Nurse Registration.

Following his election to the post of Ohio State Medical Association's President-Elect, Dr. Oscar W. Clarke was honored with a testimonial dinner sponsored by the Gallia County Medical Society at the Holzer Medical Center in Gallipolis.



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Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

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DOW PHARMACEUTICALS

OSMA Specialty Sections

SPECIALTY SECTIONS play leading roles in making plans for the OSMA Annual Meetings. They work with the Committee on Scientific Work, helping to plan programs in their respective specialties. Most of the Sections met during the 1972 Annual Meeting and elected or reelected officers. This roster brings up to date the names and addresses of chairmen, secretaries, and in some cases program chairmen of the various Sections. It is presented for the benefit of persons who may wish to correspond with officers respecting future programs. Readers are invited to notify *The Journal* office of any corrections or additions to the roster.

Section on Anesthesiology — Chairman: Joseph M. Casper, M.D., 3333 Vine Street, Cincinnati 45220; Secretary: Kenneth E. Owen, M.D., Ken-Mar Farm, Caywood Road, Route 6, Marietta 45750.

Section on Colon and Rectal Diseases — Chairman: A. Gerson Carmel, M.D., 214 Doctors Building, Cincinnati 45202; Secretary: Carlos Andarsio, M.D., 281 South Burnett Road, Springfield 45505.

Section on Directors of Medical Education — Chairman: Donald J. Vincent, M.D., Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214; Secretary: James F. Schieve, M.D., Office of Conmed, University of Cincinnati, 114 Medical College Building, Eden & Bethesda, Cincinnati 45219; Program Chairman: E. Gordon Margolin, M.D., The Jewish Hospital, 3200 Burnet Avenue, Cincinnati 45229.

Section on Ear, Nose and Throat — Chairman: Andrew W. Miglets, Jr., M.D., 320 West 10th Avenue, Columbus 43210, (Also President, Ohio Ear, Nose and Throat Society); Secretary: William J. Loeb, M.D., 11811 Shaker Blvd., Cleveland 44120, (Also Secretary, Ohio Ear, Nose and Throat Society).

Section on General Practice — Chairman: L. Eugene Plummer, M.D., 215 Marion St., Marietta 45740; Secretary: Richard C. Brandes, M.D., 2094 Tremont Center, Columbus 43221.

Section on Internal Medicine — Chairman: Donald E. Walker, M.D., 411 Wyoming Avenue, Cincinnati 45215; Secretary: Donald G. Vidt, M.D., 2020 East 93rd Street, Cleveland 44106.

Section on Neurology — Chairman: Anthony M. Iannone, M.D., Medical College of Ohio, Department of Neurosciences, P.O. Box 6190, Toledo 43614; Secretary: George A. Perrine, Jr., M.D., 130 South Davis Avenue, Columbus 43222; Program Chairman: James N. Allen, M.D., Department of Neurology, University Hospital, 410 West 10th Avenue, Columbus 43210.

Section on Neurological Surgery — Chairman: David B. Roth, M.D., 146 Wyoming Street, Dayton 45409, (Also President, Ohio Neurosurgical Society); Secretary: Philip L. Gildenberg, M.D., Cleveland Clinic Foundation, Cleveland 44106, (Also Secretary, Ohio Neurological Society); Program Chairman: David Yashon, M.D., 410 West 10th Avenue, Columbus 43210, (Also Program Chairman, Ohio Neurological Society).

Section on Obstetrics and Gynecology — Chairman: Karl Ziesmann, M.D., 4966 Glenway Avenue, Cincinnati 45238; Secretary: William C. Rigsby, M.D., 1800 Zollinger Road, Columbus 43221.

Section on Occupational Medicine — Chairman: James A. MacKay, M.D., General Electric Company, Nela Park, Cleveland 44112; Secretary: Donald W. Hillman, M.D., The Standard Oil Company, Midland Building, Cleveland 44105.

Section on Ophthalmology — Chairman: William J. Crawford, M.D., 606 Middletown Savings & Loan Bldg., Middletown 45042; Secretary: Joel G. Wachtel, M.D., 303 E. Town Street, Columbus 43215.

Section on Orthopaedic Surgery — Chairman: Clarence Hullinger, M.D., 8 W. Spring Street, Springfield 45502, (Also President, Ohio Orthopaedic Society); Secretary: John B. Roberts, M.D., 410 West 10th Avenue, Columbus 43210, (Also Secretary, Ohio Orthopaedic Society).

Section on Pathology — Chairman: Daniel Hanson, M.D., Mercy Hospital, 2221 Madison Avenue, Toledo 43624, (Also President, Ohio Society of Pathologists); Secretary: Robert G. Thomas, M.D., Dept. of Laboratories, Elyria Memorial Hospital, Elyria 44035, (Also Secretary, Ohio Society of Pathologists); Program Chairman: George C. Hoffman, M.D., Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland 44106, (Also Program Chairman, Ohio Society of Pathologists).

Section on Pediatrics — Chairman: Charles Q. McClelland, M.D., Rainbow Babies & Childrens Hosp., 2101 Adelbert Road, Cleveland 44106, (Also President, Ohio Chapter, American Academy of Pediatrics); Secretary: George Smith, M.D., 908 Fountain Avenue, Springfield 45504, (Also Secretary, Ohio Chapter, American Academy of Pediatrics).

Section on Physical Medicine and Rehabilitation — Chairman: John L. Melvin, M.D., University Hospitals, 410 W. 10th Avenue, Columbus 43210, (Also President, Ohio Society of Physical Medicine and Rehabilitation); Secretary: Nicholas S. Checkles, M.D., University Hospitals, 1030 Dodd Hall, 472 W. 8th Avenue, Columbus 43210, (Also Secretary, Ohio Society of Physical Medicine and Rehabilitation); Program Chairman: Ian C. MacLean, M.D., University Hospitals, 410 W. 10th Avenue, Columbus 43210, (Also Program Chairman, Ohio Society of Physical Medicine and Rehabilitation).

Section on Plastic Surgery — Chairman: John D. DesPrez, M.D., 11811 Shaker Blvd., Cleveland 44120; Secretary: Henry E. McWhorter, M.D., 3939 Monroe Street, Toledo 43606; Program Chairman: Ronald Berggren, M.D., University Hospitals, 410 West 10th Avenue, Columbus 43210.

Section on Psychiatry and Neurology — Chairman: L. E. Whitmire, M.D., 3450 West Central Avenue, Toledo 43606, (Also President, Ohio Psychiatric Association); Secretary: Walter Stone, M.D., Central Clinic, Cincinnati General Hosp., Cincinnati 45299, (Also Secretary, Ohio Psychiatric Association); Program Chairman: Robert E. Walden, M.D., Medical College of Ohio, P.O. Box 6190, Toledo 43614, (Also Program Chairman, Ohio Psychiatric Association).

Section on Radiology — Chairman: Joseph H. Hanson, M.D., 1544 S. Byrne Road, Toledo 43614, (Also President, Ohio State Radiological Society); Secretary: Thomas F. Ulrich, M.D., 400 W. Tuscarawas Ave., Barberton 44203, (Also Secretary, Ohio State Radiological Society); Program Chairman: Tearle L. Meyer, M.D., 175 S. Merkle Rd., Columbus 43209, (Also Program Chairman, Ohio State Radiological Society).

Section on Rheumatology — Chairman: Vol Philips, M.D., 1211 Dublin Road, Columbus 43209, (Also President, Ohio Rheumatism Society); Secretary: Joseph E. Levinson, M.D., Convalescent Hospital for Children, Auburn Ave., and Wellington Place, Cincinnati 45219, (Also Secretary, Ohio Rheumatism Society); Program Chairman: Allen Mackenzie, M.D., 9500 Euclid Avenue, Cleveland 44106.

Section on Sports Medicine — Chairman: Sol Maggied, M.D., 15 East Pearl St., West Jefferson 43162; Secretary: James C. Good, M.D., 5594 North High St., Worthington 43085; Program Cochairmen: Robert J. Murphy, M.D., 1975 Guilford Rd., Columbus 43221 and Richard F. Slager, M.D., 815 W. Broad Street, Columbus 43222.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during June. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland)
Chan Hyun Ahn
Frederick A. Heupler, Jr.
Seungwoo Rho
Krishna P. Saigal
Roger W. Sherman
Ming-Hwa Sun
Sook-Kyung Yoo

HAMILTON (Cincinnati)
George M. Callard
Robert C. Leroux
Alan M. Linder
Richard G. Santangelo
Thomas F. Teller

LORAIN
Ramon C. Castro
Lorain

LUCAS
Antonio Yap
Toledo

MONTGOMERY (Dayton)
Iradj Fazel
Stephen T. House

RICHLAND
Robert A. Struble
Mansfield

SCIOTO
Daniel A. Martelino
Wheelersburg

SUMMIT
George I. Litman
Akron

TRUMBULL
Hee Won Chung
Warren

Physician's Bookshelf

Medical Writing, The Technic and the Art, Fourth Edition, by Morris Fishbein, M.D., published by Charles C. Thomas, Publisher, 301-327 E. Lawrence Avenue, Springfield, Illinois; price, $9.75.

This revised edition of a well-known text is of particular interest to the editorial staff of *The Journal* and, we trust, is also of interest to physicians who write, or wish to write on medical topics.

The text of this book was developed by the author out of many years of experience in the selection of manuscripts for publication, the preparation of manuscripts for the printer, and the work involved in seeing the article through the press to the time when it appears before the reader.

Dr. Fishbein is editor of *Medical World News* and medical editor of *Britannica Book of the Year.* He is former editor of *The Journal of the American Medical Association,* undisputed leader in the medical publication field.

Special chapters cover such basic subjects as the choice of words, the style of writing, the avoidance of jargon, and the technical details in preparing a manuscript that will incline the editor toward approval and acceptance for publication. Examples, taken from actual manuscripts, illustrate good and poor writing.

In the text's introduction the publishers state, "The quality of contributions to medical literature is constantly improving. Far too often, however, physicians still prepare their contributions with a striving and agony and delay comparable to the delivery of human progeny by one untutored in the refinements of obstetrics."

The physician or medical student, whether or not experienced in writing, would do well to read this book as a text. A good index makes it a ready reference to keep on the bookshelf.

As pointed out by the publishers, "Professional writers in every field of literature realize the **importance of preparing a manuscript for the publication for which it is meant. . . .** Obviously the physician who is preparing an article for a state medical journal, for one of the periodicals devoted to a medical specialty or for any other medical periodical should be familiar with the nature of the publication and should plan his article according to the usual pattern followed by that publication." Most publications have a prepared style sheet or instructions for prospective authors which is available for the asking.

★ ★ ★

Medical Students—Family Doctor—Citizen is the title of a book in process of being published under the authorship of Nino M. Camardese, M.D., Norwalk physician and outspoken proponent of continuation of the free choice of physician concept.

His 256-page book in part is his effort to encourage medical students and young physicians to direct their efforts toward family practice. Several guest authors have contributed chapters to the book.

Current plans are that any profits realized from the sale of the book will go toward Project Hope, a program of the Association of American Physicians and Surgeons, or the "Dollars for Scholars" project sponsored by Dr. Camardese.

Inquiries may be directed to Dr. Camardese at 48 N. Linwood Ave., Norwalk, Ohio 44857.

Outstanding Scientific Exhibits at 1972 Annual Meeting

AMONG FEATURES of the 1972 OSMA Annual meeting held in Cincinnati, May 8-11 were the scientific, health education, and technical exhibits displayed in the Cincinnati Exposition Center.

Several exhibits were selected as outstanding by a judging committee and the sponsors were presented certificates of recognition and permanent type plaques to be displayed on respective exhibits and afterwards kept as mementos.

A summary of exhibits selected to receive special recognition was published in the July issue of *The Journal,* page 695. Following is additional information on three of these exhibits. Additional information on other award winners will be published later.

Gold Award Goes to Teaching Exhibit on the Eye

The Gold Award in the teaching field was presented to the exhibit entitled, "Know Your Eyes," a presentation on anterior segment eye diseases sponsored by Ira A. Abrahamson, Sr., M.D., Ira A. Abrahamson, Jr., M.D., and Leonard Jacobson, M.D., of the Department of Ophthalmology, University of Cincinnati College of Medicine.

This teaching exhibit is presented in an unusual and interesting manner. The observer studies Kodachrome slides, and is invited to make his own diagnosis. He then flips a tab and compares his diagnosis with the findings presented by the sponsoring team. With changes from time to time, the observer has access to almost a thousand slides representing common and rare anterior segment eye diseases.

The exhibit as presented was modernized and updated, but it is unique in respect to its background. The sponsors have expanded the exhibit over a period of years by continually adding slides compiled through their experiences and observations. A similar exhibit on the subject was presented at the OSMA Annual Meeting of 1956 in Cleveland and at other OSMA Annual Meetings since. The slides used for the current exhibit are part of a library of over 32,000 slides.

The exhibit has won awards in teaching at the Kentucky Medical Association Annual Meeting as well as at the OSMA meeting; also at meetings of the American Academy of Ophthalmology, American Academy of Pediatrics, Pan-American Congress of Ophthalmology, and the American Academy of Family Physicians.

So great was the demand by physicians for pictures shown in the exhibit that a text entitled, "*Anterior Segment Eye Diseases*" was published by McGraw Hill Publishing Company in 1964. Illustrations from the exhibit have been converted into slide series and are available from Medcom, Inc., 2 Hammarskjold Plaza, New York, N.Y. 10017. Included in the series are Dermatologic-Ophthalmology, Pediatric Ophthalmology, The "Red Eye," Corneal Ulcer Management, and Ophthalmic Manifestations of Medical and Neurological Conditions.

Gold Award Goes to Exhibit on Hypertension

The Gold Award in original investigation was presented to the exhibit entitled, "Management of Hypertensive Emergencies," sponsored by Donald G. Vidt, M.D., and Ray W. Gifford, Jr., M.D., of the Department of Hypertension and Nephrology, Cleveland Clinic Foundation.

The exhibit was designed to review concisely the drugs available and their uses in the management of hypertensive crises. The various crises are outlined together with their complications.

Preferred drugs and alternate preparations were presented, with precautions for the use of certain drugs.

The exhibit sponsors passed out at the booth a pamphlet entitled, "A Manual for the Management of Hypertensive Emergencies," which reviews in concise form the high points of the exhibit. A limited number of copies are available from the sponsors at the Cleveland Clinic, 9500 Euclid Avenue, Cleveland 44106.

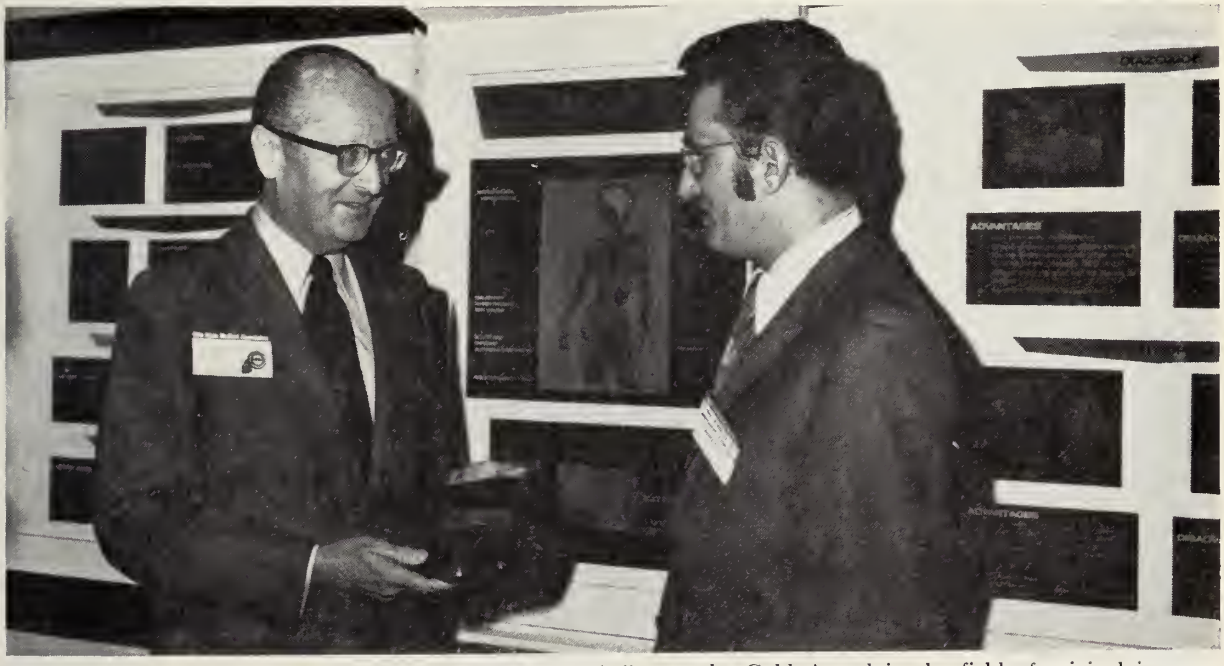
Exhibit on Obesity Given Silver Award

The Silver Award in original investigation was presented to the exhibit entitled, "The Metabolic Abnormalities of Obesity," sponsored by Irving B. Perlstein, M.D., of the University of Louisville School of Medicine.

The purpose of this exhibit was to point out as clearly as possible to visiting physicians that



Displaying the Gold Award in the teaching category are sponsors of the exhibit, "Know Your Eyes." From left, are Dr. Ira Abrahamson, Jr., Dr. Ira Abrahamson, Sr., and Dr. Leonard Jacobson.



The exhibit, "Management of Hypertensive Emergencies," won the Gold Award in the field of original investigation. Here Dr. William R. Schultz, Incoming OSMA President, presents the plaque to Dr. Angel L. Rivera, who helped the sponsors, man the exhibit.

obesity is not a single problem, but one phase of a multifaceted problem in metabolic disturbances. It was hoped that the stimulus derived from this exhibit might adequately arouse interest in physicians to begin treating obese patients who have been for so long pushed to the sidelines.

Abnormalities in carbohydrate metabolism were shown to exist in a high percentage of individuals 30 pounds or more over ideal weight. Additionally, serum insulin studies run concomitantly with the glucose tolerance curves showed extremely abnormal variations in the levels of serum insulin which could contribute to abnormal fat storage. The incidence of lipid abnormalities, of hypertension, and of heart disease, was clearly demonstrated to be increased in the obese phase and to diminish as weight reduction was achieved and maintained. Vascular studies as demonstrated by skin biopsies even in obese young people showed markedly abnormal arteriolar changes.

The exhibit tries to point up the drastic need for a complete and meticulous physical examination and laboratory study as well as careful inquiry into the history of the genesis of the obesity. New tests involving thyroid hormone transport and thyroid autoantibodies were described in detail. The incidence of depression in obese individuals was related to the biochemical phenomena which took place in their body concomitantly with the manifestation of weight gain.

The long term management of obesity was discussed in detail. Emphasis was placed on the management of this disturbance as a chronic disease.

The exhibit made it imperative that the physician assume responsibility for obese patients, rather than have them drift into the hands of untrained lay groups and health spas. The benefits to be gained by the patient from proper management was shown in the long term followups and in the statistical analysis which was included.



The Silver Award for original investigation went to Dr. Irving B. Perlstein, sponsor of the exhibit on "The Metabolic Abnormalities of Obesity." Dr. Schultz is shown making the presentation.

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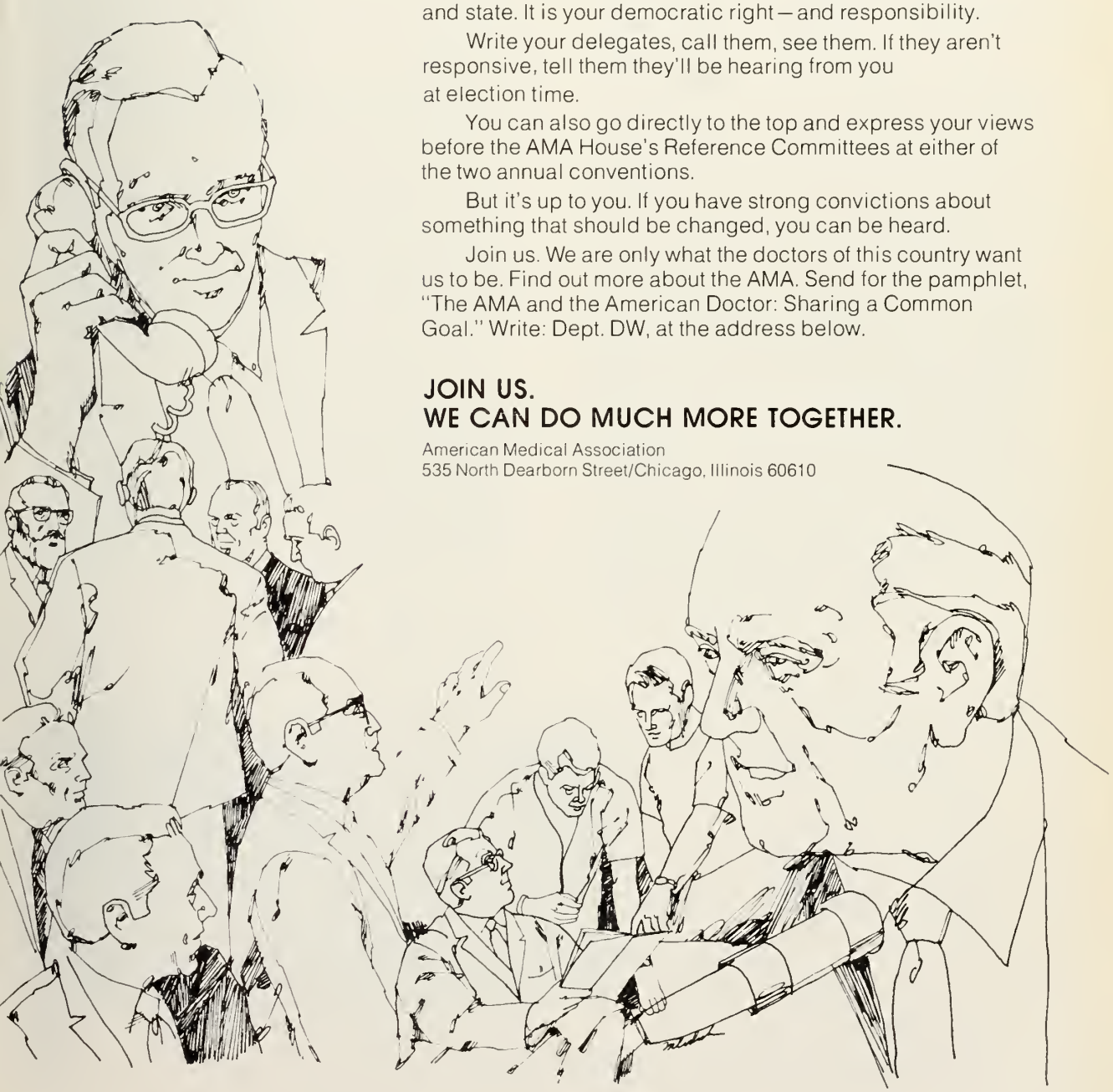
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

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American Medical Association
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Effective Political Action by Medicine NOW Is a Must

SUBSTITUTE "physicians" for "businessmen," "medical profession" for "business," "scrub room" for "Board Room" and "AMPAC-OMPAC" for "BIPAC" in the following piece published in *Politics,* monthly bulletin of the national business-industry political action committee. You wind up with some potent advice and practical suggestions for forceful action on the part of the medical profession in this Election Year, 1972. To quote the article in part:

"Businessmen grumble on the golf course and complain in the Board Room about rising taxes, union power, a sluggish market, restrictive rulings by government agencies and all the other annoyances of trying to make a profit. Such overwhelming problems require some measure of action from the business community.

"In the last decade under a liberal/labor dominated Congress, the principles of free enterprise have given way to governmental intervention to a degree that would make the New Deal look pale in comparison. The governmental bureaucracy makes daily inroads on the entrepreneur's right to do his own pricing and marketing. Quasi-official agencies spew out restrictive guidelines and regulations with little regard for need, effectiveness, or potential damage to the business sector.

"Everyone knows that the answer lies in the chambers of the Congress. A strong, forceful majority in the House and Senate that would respect the right of business to operate profitably can be more than a wistful pipedream if business decides to act NOW.

"For too long, businessmen have adopted the attitude that politics should be left to the politicians. Business has too often turned the other cheek or has made unsuccessful attempts to "lobby" congressmen already committed to a liberal/union stance. The most effective time to exercise political muscle is prior to the election-when candidates favored by business are too often defeated for lack of adequate support.

"The gauntlet has been thrown in this fall's elections and the business community has the opportunity—indeed the responsibility—to take up the challenge.

- "Know the records of the candidates. If he is an incumbent, his previous service should be a guide to his ideological persuasion.

- "Contribute a little money and time to your chosen candidates, the local party of your choice, and the national party of your choice.

- "Become a member of an industry or nationwide political action committee (BIPAC, for example) which can represent your interests in every congressional race where help is needed.

- "DO SOMETHING.

"The tens of thousands of businessmen who don't have enough of a political conscience to give support to candidates who reflect their views have no cause to moan after the elections. Businessmen will get the kind of Congress they deserve for the effort they put forth."—*Ohio Medical Political Action Committee.*

Ohio Heart Affiliate Names Officers for Year

Dr. J. Lester Kobacker, Toledo, was installed as president of the Ohio Affiliate of the American Heart Association at its Annual Meeting held in Columbus recently.

Other officers elected are Raymond A. Brownsword, Akron, chairman of the Board; Dr. Jack S. Silberstein, Columbus, secretary; C. Richard Newpher, Cleveland, treasurer; and John S. Andrews, Youngstown, assistant treasurer.

Dr. Louis A. Black, Kenton, and Dr. Samuel Kaplan, Cincinnati, are new members elected to the Executive Committee.

American Heart Association, Ohio Affiliate, Inc., has its headquarters at 10 East Town Street, Room 506, Columbus 43215. Walter S. Page, Jr., is executive director.

Obituaries

Albert Raphael Andrisek, M.D., Cleveland; Loyola University Stritch School of Medicine, 1931; aged 67; died May 26; member of OSMA, AMA, American Society of Abdominal Surgeons, and American Geriatrics Society; practitioner in Cleveland for some 40 years and physician for the Cleveland school system for 25 years.

William Robert Boyd, M.D., Willoughby; University of Wooster Medical Department, Cleveland, 1906; aged 89; died June 4; member of OSMA and AMA; practitioner in the Willoughby area for 49 years.

Joseph Harry Dempsey, M.D., Cleveland; St. Louis University School of Medicine, 1950; aged 51; died June 13; member of OSMA and AMA; Fellow, American College of Obstetricians and Gynecologists; practitioner in the Cleveland area for virtually all of his professional career.

Joseph Edward Duty, Sr., M.D., Toledo; Ohio State University College of Medicine, 1937; aged 60; died May 26; member of OSMA, AMA, and American Psychiatric Association; associated with mental hygiene programs in Ohio for many years and former Commissioner of Mental Hygiene for the State; former superintendent of the Toledo Mental Health Center, and in recent years regional assistant commissioner for the Northwestern Ohio Mental Hygiene Division. A son, Dr. Joseph E. Duty, Jr., is a Toledo physician.

Robert Charles Hahn, M.D., Elyria; Western Reserve University School of Medicine, 1931; aged 66; died June 1; former member of OSMA; diplomate of the American Board of Surgery; practicing surgeon in the Elyria area for many years; veteran of World War II.

William Myron Hall, M.D., Cleveland; Howard University College of Medicine, 1923; aged 79; died June 16; member of OSMA, the American Academy of Family Physicians, and the National Medical Association; former member of AMA; general practitioner in Cleveland since 1950 when he moved there from Charleston, W. Va., veteran of World War I.

George Paul Hohly, M.D., Glendale, Calif.; University of Illinois College of Medicine, 1904; aged 94; died June 17; member of OSMA and AMA; former practitioner of long standing in Toledo; past president of the Academy of Medicine of Toledo; former Lucas County coroner and past president of the Ohio Coroners Association; resident of California for less than a year.

Samuel Bartlett Kistler, M.D., Coshocton; Ohio State University College of Medicine, 1928; aged 67; died June 7 in Florida; member of OS-



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HERBERT A. SIHLER, Jr.
President

MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

MA, and AMA; Fellow, International College of Surgeons; practitioner since 1931 in Coshocton where he specialized in the EENT field. Dr. Jack B. Kistler, of Riverside, Calif., is a son.

Harry G. Lieberman, M.D., Akron; Ohio State University College of Medicine, 1936; aged 63; died June 3; member of OSMA, AMA, American Rheumatism Association, and American Academy of Family Physicians; general practitioner for 35 years in Akron; veteran of World War II.

Lawrence Brooks Mehl, M.D., Akron and Cuyahoga Falls; Ohio State University College of Medicine, 1930; aged 67; died June 1; member of OSMA and AMA; Fellow, American College of Obstetricians and Gynecologists and the American College of Surgeons; diplomate, American Board of Obstetrics and Gynecology; resident of Akron for 42 years and practitioner with offices in Cuyahoga Falls; veteran of World War II.

Frank Augustus Riebel, M.D., Columbus; Ohio State University College of Medicine, 1925; aged 68; died June 8; member of OSMA, AMA, and Radiological Society of North America; Fellow, American College of Radiology; diplomate, American Board of Radiology; practitioner in Columbus for many years and chief of radiology at Mercy Hospital; member of the faculty at the OSU College of Medicine. Dr. Barbara Griffith, of Mt. Holly, N.J., is a daughter.

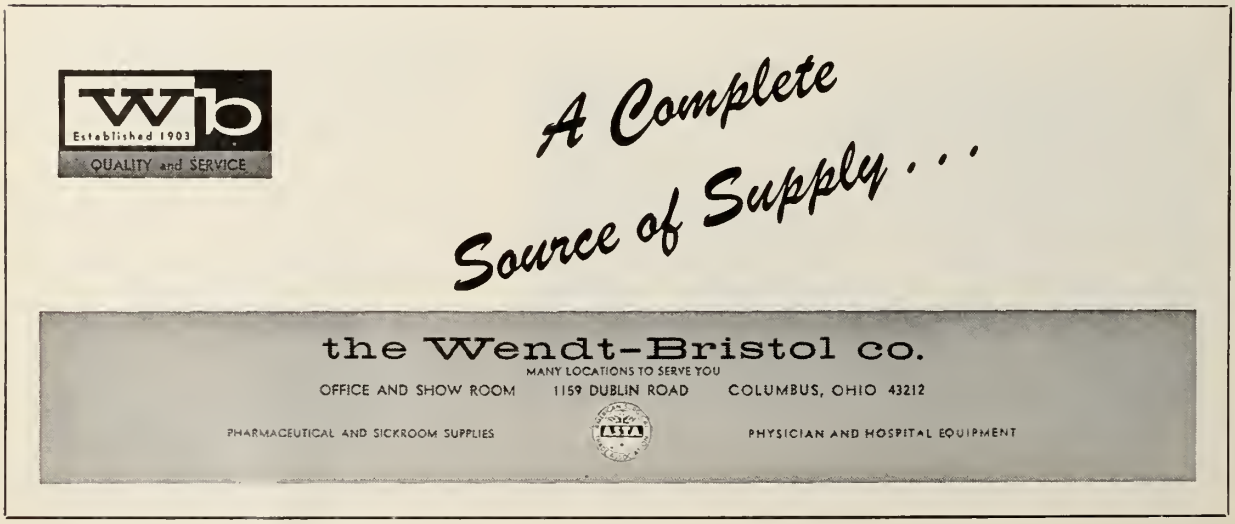
Wilbur Franklin Stewart, M.D., Fostoria; Loyola University Stritch School of Medicine, 1933; aged 72; died March 25; member of OSMA and AMA; practitioner of long standing in the Fostoria area where he specialized in the EENT field; veteran of World War II.

Francis McLeish Stratton, M.D., Delaware; Cleveland Pulte Medical College, 1903; aged 96; died June 13; member of OSMA and AMA; general practitioner of long standing; practiced for many years in Williams County before moving to Delaware in 1923; veteran of both the Spanish-American War and World War I.

Thomas Luther Taylor, M.D., Montpelier; Ohio State University College of Medicine, 1935; aged 71; died June 20; member of OSMA and AMA; practitioner in the Montpelier area since 1937 and Williams County health commissioner for many years; veteran of both World Wars I and II.

Albert Joseph Tremblay, M.D., Toledo; Ohio State University College of Medicine, 1951; aged 49; died June 1; member of OSMA and AMA; practitioner in Toledo for 20 years; veteran of World War II.

John Martin Wittenbrook, M.D., Cleveland; Western Reserve University School of Medicine, 1936; aged 61; died May 29; member of OSMA, AMA, the American Psychiatric Association and the Central Neuropsychiatric Association; practicing psychiatrist in the Cleveland area and psychiatric consultant to a number of institutions.




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Woman's Auxiliary Highlights

Report on the National Convention in San Francisco

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

THIS IS CALIFORNIA—a land of contrasts. Palm trees, evergreens and exotic flowers—desert and naked mountains—irrigation ditches and the vast stretch of the Pacific Ocean—missions and wineries—the Farmer's Market and Chinatown—of course, I could go on and on and begin to sound like California's Chamber of Commerce! Perhaps the fact that I'm vacationing here (but with no "vacation" from this column!) following the convention of the Woman's Auxiliary to the American Medical Association, I'm "steeped deep" in my surroundings. . . .

But I must shake myself loose and move back to San Francisco and the St. Francis Hotel and the fiftieth anniversary of our National Auxiliary. It all began with the opening session of the 121st annual meeting of the American Medical Association in the Continental Ballroom of the San Francisco Hilton Hotel. And it was quite an occasion—this tribute of the men's House of Delegates in honor of the Woman's Auxiliary.

There was an 18-piece orchestra to welcome us, featuring songs whose heyday was in the twenties. Everything from "Ma, He's Making Eyes At Me" to the "Charleston" and ad infinitum . . . **Three thousand** men and women crowded the ballroom. And when those three thousand voices were raised in singing "The Star Spangled Banner," it was a magnificent and spine-tingling moment.

On the podium, along with the officials of the AMA, sat a remarkably good representation of the past presidents of the National Auxiliary, including Mrs. G. Prentiss Lee, the 1971-72 president, and Mrs. Robert F. Beckley, president-elect. Among those past presidents was Ohio's own Mrs. Karl F. Ritter.

Dr. Wesley W. Hall, 1971-72 President of the AMA, presented Mrs. Lee with a handsome bronze plaque that reads in part the "American Medical Association offers heartfelt thanks for the auxiliary's half century of service" . . . Dr. C. A. Hoffman, incoming AMA President, presented Mrs. Beckley with 50 roses in honor of the golden anniversary.

"Beyond the Window"

The "flashback" presentation of the history of the Woman's Auxiliary was beautifully and vividly portrayed. Based on a script by two past presidents, Mrs. Harlan English and Mrs. Rodney Stoltz, the "Beyond the Window" was a multi-media show that artfully combined multi-screen images of slides, film strips, photo-montage and original art work with live action, narration and music. The presentation was designed to project a kaleidoscopic picture of the growth and development of the auxiliary. It was directed by Eleanor Chappell and featured members of the auxiliary teamed with professional actresses and actors.

I could wish that it were feasible to flash on this page that visual and highly effective presentation, but perhaps some word picture taken from "The Right Side of the Caduceus" (especially prepared for the anniversary) will dramatize effectively "the beginning": The place is St. Louis, Missouri; the date, Wednesday, May 24, 1922. The meeting of the House of Delegates of the American Medical Association is in progress. Dr. Edward H. Cary, of Dallas, Texas, requests the floor and presents the following resolution, prepared by the Woman's Auxiliary to the State Medical Association of Texas, of which Mrs. Samuel Clark Red, of Houston, is president.

"The Woman's Auxiliary to the State Medical Association of Texas respectfully requests the approval of the American Medical Association of a movement to organize a Woman's Auxiliary to the American Medical Association, the object of which shall be, 'To extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education, to assist in entertaining at all medical conventions and to promote acquaintanceship among doctors' families so that closer fellowship may exist.' "

Discussion of the resolution follows. It is stated, "The present plan does not appear to involve any financial or other obligation on the part of this association." The resolution is approved. With Mrs. Willard Bartlett, of Missouri, as chair-

man of the Ladies' Committee, it was arranged that Mrs. Red address the 200 wives who had accompanied their husbands to the convention. Mrs. Red announced an organization meeting for Thursday morning in the Palm House of the Missouri Botanical Gardens.

Mrs. Samuel Clark Red

The weather did not cooperate with the plans and, as a result, many visitors took cover near the entrance of the gardens. This made Mrs. Red's task extremely difficult. Undaunted, Mrs. Branford Lewis, chairman of the morning, assisted Mrs. Red to the nearby steps, raised a megaphone to her lips and presented the enthusiastic Mrs. Red to the group. Despite the awkward circumstances, her message was heard by the visitors and all were urged to attend an organizational meeting on the following morning, May 26, 1922, at the Statler Hotel. Three St. Louis women were selected to serve on the committee to consider plans for the formation of such an organization at an early date. Twenty-three women from ten states are recorded as being present. The national auxiliary's first president was Mrs. Samuel Clark Red, of Texas. (Her son was a guest of honor at the fiftieth anniversary of the auxiliary she did so much to bring into being . . .)

This is the actual story of the small beginning of the Woman's Auxiliary to the American Medical Association. Yet auxiliaries to medical societies existed before 1922. Oklahoma, Minnesota, South Dakota, Maine and Texas had functioning auxiliaries for some years before the resolution was presented to the AMA. (Ohio did not organize until 1940). In those early years—1906 to 1918—the objectives of the auxiliary were primarily social ones. Doctors' wives were referred to as "visiting ladies" and to entertain them while their husbands attended the sessions of the AMA was considered the auxiliary's prime function.

The Newer "Format"

During World War I, knitting and working with the Red Cross were added to the purposes of these early auxiliaries. A new interpretation was given to "promoting acquaintance and good fellowship among the families of physicians," since many were leaving for military service. The words **Patriotic** and **philanthropic** were added to the phrase "social activities" and a new concept of a medical auxiliary was born. By 1922, the objectives presented to the AMA House of Delegates reflected this change of concept. Before too long, the purely social aspect was de-emphasized until, 50 years later, "entertaining visiting ladies" at conventions has become incidental.

The reporting of the accomplishments of the state auxiliaries and the guidance and assistance proffered by the national officers and chairmen to the states have replaced, to a large extent, the automobile rides, dances, tours, bowling, bathing, moonlight sails and train rides advertised in those bygone days. To cultivate friendly relations and promote mutual understanding among physicians' families became Object No. 3 in the bylaws in 1951, but doctors' wives of 1972 achieve this objective by planning and working together and with others. To an auxiliary member, it is not achieved merely by attending a convention with her husband.

One cannot review the 50-year activities of the auxiliary without noting "Times Change and We Change with Them." Many changes took place in organization, structure, policies and projects. Sometimes the changes were obvious and dramatic; sometimes well-nigh imperceptible. One outstanding example—activities in the field of legislation. At the early conventions, representatives from the AMA spoke words of encouragement to the young organization and told repeatedly of its value. However, almost without exception, they warned against any activity in the field of legislation. The auxiliary heeded their admonitions, even going so far that we read on April 23, 1926, "The name of the committee on legislation was changed to committee on public relations and this because the auxiliary wished to emphasize that it is against the participation of its members in legislative work."

Times Change!

Interestingly enough, the auxiliary *Bulletin* in October of 1928 carried an article written by the public relations chairman outlining bills "in which the AMA is involved or interested." The purpose of the article was that wives "should have some knowledge of legislation which may affect their husbands professionally or economically." Then came the thirties—depression, unemployment, the New Deal, Repeal, and so on and on.

The Roosevelt administration extended itself into vast new fields . . . Quite unexpectedly, a new chord is struck in inaugural addresses of the auxiliary presidents. If the opportunity offers, keep yourself informed on legislation of interest to the medical profession and, if requested by your state medical society, help when possible."

Then came World War II and before long the Wagner-Murray-Dingell Bill for compulsory government health insurance. In 1945, the AMA in unprecedented action officially requested the

auxiliary "to use every avenue possible to bring information concerning hazards of current medical legislation to its members and through them to the public." From this time forward, all hesitancy regarding active participation on the legislation scene ceased and presidential directives became more explicit and outspoken . . .

Obviously, if regretfully, it is impossible to cover in this column even the highlights of the auxiliary's fifty years. However, it is this reporter's hope that from time to time she may be able to include in future columns some more of the colorful background of auxiliary history. Now I move on to another kaleidoscopic picture of other convention "doin's"—

Ohio Wins Two Awards!

It was exciting, of course, to find ourselves in the "winner's circle" this year for our AMA-ERF efforts. We won the Regional Merit Award for the state auxiliary with the greatest increase over last year in total dollars contributed in the North Central Region and we won recognition for our 1971-72 $14.50 per capita in AMA-ERF contributions. Hats off to our 1971-72 president, Mrs. Russell Wiessinger, and to her AMA-ERF chairman, Mrs. Karl Ulicny. Our "prize" is a beautiful gold scrapbook suitably inscribed by AMA-ERF.

The amount contributed this year from auxiliaries all over the country totalled $740,388.58. In actual amounts, California led again with $114,961.00, with Ohio coming in second with more than $73,000.00 (A point worth noting: California's membership is almost double that of ours!)

The grand total in contributions to AMA-ERF from the national auxiliary since 1951 is a whopping $5,487,399.05! If we're close to bursting with justifiable pride, who can blame us???

Another Honor

The new North Central regional legislation chairman is none other than our own Mrs. Malachi W. Sloan, II, past state president. Congratulations, Jane. This makes two Ohio women serving on the national level (Mrs. J. Paul Sauvageot is editor of *MD's Wife*.)

Monday's Luncheon

It was the annual luncheon honoring AMA officers, trustees and their wives. The Grand Ballroom at the St. Francis provided the setting. Art Linkletter, famous television personality, provided the provocative program. "Drugs are as available as Lollipops," he said. Here are just a few of his other pertinent remarks: we have a people problem; we do not have a drug problem—we have a pill popping society—we have come to rely on pills as if we believe that relief from any kind of anxiety is just a swallow away—cocaine is now the real 'upper' (snow), with more grammar school children using it than ever—schools should begin teaching the dangers of drugs at the first grade level . . .

Mr. Linkletter spoke beautifully and tenderly of his daughter. He said that the 20-year-old girl had not "been a bad girl, had not been an addict." He pointed out the important role doctors' wives must play in helping to fight the drug abuse problem. Address yourselves to your community, he urged. "Help to save our most precious possession, the young people" . . . I doubt that anyone in that vast Grand Ballroom was left unmoved by Mr. Linkletter's challenging presentation.

"Bits and Pieces"

When I attempt to write up a national convention, it's always something of a problem. Where to begin and where to end, what to include and what, of necessity, to omit . . . This year the problem is greater than ever because of the fiftieth anniversary celebration. There was so much to do and to see, to observe and to absorb, to listen to and to "tuck away." And because all work and no play can make Jill a dull girl, there was social activity and good fellowship and that always cherished "mingling."

And so here's my *very* condensed version of some additionally important moments in San Francisco: Ohio's traditional breakfast for its delegates and the wives of OSMA delegates (this year we had the privilege of having Mrs. John Robechek and Mrs. Oscar Clarke; Mrs. Robechek is the wife of the 1971-72 OSMA President, and Mrs. Clarke is the wife of the new OSMA President-Elect).

There was the gala reception for Mrs. G. Prentiss Lee national president, and Mrs. Robert F. Beckley, president-elect, that included champagne and delectable hors d'oeuvres. The champagne glass, duly inscribed, was our "souvenir" of the momentous occasion of the fiftieth anniversary.

There were, of course, the three business sessions, the "Ideas Exchange," the reports of the state presidents (Ann Wiessinger did Ohio proud) the election of the 1972-73 officers and directors. There was the impressive installation. There was the forceful talk by Victor Weingarten, director of The President's Committee on Health Education. Nor Could I possibly omit mention of the glamorous and breath taking style show—"Ori-

ental Splendor"—the fashions of the "City of Shanghai" in San Francisco). The satins and silks swished by us intriguingly at Tuesday's luncheon.

There was Mrs. Beckley's inaugural address in which she asked "what more can we do?" She quoted Winston Churchill's "the farther backward we look, the more in the future we see." She said that her year would stress health education and health services.

And there was that Napa Valley Wine Tour and luncheon at the Charles Krug Winery and the visits to other wineries and the wine-tasting and cheese-munching at the beautiful Robert Mondavi Winery that is designed in Early California Mission style. Each winery included in the tour (eight!) provided samples of their wines at the tasting session. (we did make it back to the St. Francis without any casualties!!)

There was the night scene from the "Top of the Mark" that defies description. There was, as always, the cable cars and their "hangers-on." There was the fascination of Chinatown and the calorie-devastation of San Francisco's fabulous restaurants. There was Fisherman's Wharf and one unhappy memory—my roommate's wallet was "lifted" . . . there was the new addition to the St. Francis—very modern, very elegant.

And last, but most assuredly not least, there were the 17 delegates from Ohio plus the Presidential delegate, Mrs. Russell Wiessinger (Lima) Chairman of delegates was Mrs. Louis Loria (Bristolville). The others included:

Mrs. Nathan Gordon (Akron), Mrs. Emil Barrows (Cincinnati), Mrs. D. L. Becker (Lima), Mrs. H. A. Crawford (Cleveland), Mrs. Carl F. Goll (Steubenville), Mrs. Karl Ulicny (Salem), Mrs. Reuben Gould (Cleveland), Mrs. Jerry Hammon (West Milton), Mrs. C. A. Colombi (Cleveland), Mrs. Samuel L. Meltzer (Portsmouth), Mrs. Malachi W. Sloan (Dayton), Mrs. J. R. Kreischert (Van Wert), Mrs. Daniel Wolff (Toledo), Mrs. George Osler (Cincinnati), Mrs. Richard Champion (Akron) and Mrs. S. J. Glueck (Springfield).

For the 18 of us lucky enough to have served as delegates, there are so many golden moments to remember and savor on this golden anniversary of the Woman's Auxiliary to the American Medical Association!

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Methyltestosterone N.F.-10 mg.

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Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-ei 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.

Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINOICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

OOSAGE ANO AOMINISTRATION: Oosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INOICATION	Average Oaily Oosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg in bottles of 60, 250.

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Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents, diuretics, anticholinergics and antacids.

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Safety: An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

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Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules
up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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SEPTEMBER • 1972
VOL. 68 NO. 9

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



The Laser As an Art Medium

For more on physician-sponsored art, see page 891

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EXCHANGE OFFICE
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The negative power of clinically significant anxiety in angina pectoris...



This man feels he is living on borrowed time.

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28 SEP 1972

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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FDA Action Is Warning on Diapulse Machine

The American Medical Association recently sent out in telegram form a news release made public by the U.S. Food and Drug Administration, which reads as follows:

"The Food and Drug Administration today (July 30) announced seizure of two diapulse devices. The manufacturer, Diapulse Corp. of America, has been permanently enjoined from shipping or selling its products in interstate commerce.

"The seizure action was against diapulse units in possession of a Norfolk, Va., hospital. It is the first of a number of seizure actions the FDA expects to take as a result of a recent court ruling.

"Over 4,000 diapulse devices have been distributed throughout the U.S. and in several foreign countries. Purchasers include hospitals, clinics, medical doctors, chiropractors and other practitioners who have paid $2,400 to $3,000 for each machine.

"Diapulse resembles a conventional diathermy machine which is used to produce deep heat treatment. FDA has concluded, however, that on the basis of laboratory and clinical tests there are no known therapeutic benefits to be derived from the use of the diapulse. This view has been supported by the courts. In October 1969, the government stopped paying claims under the Medicare program for diapulse treatments."

'Hazardous to Your Health'

Hazardous to Your Health is the name of a new book by Marvin H. Edwards, editor of *Private Practice*. Speaking about the new book, Frank D. Campion, director of the American Medical Association's Communications Division, said: "(It) seems to me the best and most thoroughly documented case against compulsory national health legislation I have ever seen." The book is published by Arlington House, 81 Centre Ave., New Rochelle, N.Y. 10801.

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Ohio Area to Be Part of Health and Nutrition Survey

The following report was furnished to *The Journal* by Harris Lilienfeld, M.D., medical officer with the Department of Health, Education and Welfare.

About 470 persons aged 1-74 years from Cuyahoga and Lake Counties will be invited to receive health and nutrition examinations in a study beginning September 1 and ending October 7, 1972 in the Cleveland metropolitan area. The examining program is part of a nationwide survey of young persons and adults conducted by the Health and Nutrition Examination Survey of the U.S. Public Health Service.

The Survey will examine a representative sample of the U.S. population over the next two years, visiting 64 locations throughout the country for this purpose. The Survey will be collecting uniform statistical information on selected chronic disease conditions and on the nutritional status of the population aged 1-74 years. Persons to be examined are selected by scientific sampling techniques and invited to participate in the data-collecting process. Examinations are conducted at the Survey's mobile examination center, which will be set up at a central location.

Each examination team consists of: a general examining physician, dermatologist, ophthalmologist, dentist, nurse, laboratory technician, two health technicians, secretary, three nutritionists, and supporting staff of administrative personnel and interviewers.

All data and information collected from those individuals participating in the Survey are used for statistical purposes only and are strictly confidential. A copy of examination findings, including laboratory findings (hemoglobin, red and white cell counts, cholesterol, iron, vitamin levels, etc.) may be made available to an examinee's personal physician or clinic physician should this be requested and authorized by the examinee. Findings of the examination are not made available to the examinee by the examining staff, but rather through his physician, who is best able to interpret the findings and possible significance of such for the individual involved.

Operationally, the Survey is preceded in each area by interviewers from the Bureau of the Census, who visit the selected census tracts for the purpose of identifying the eligible persons and collecting related information. From this list of eligibles, a number of sample persons is selected and later contacted by Health and Nutrition Examination representatives, who explain the Survey, seek authorization for participation, and arrange appointments for the examination and transportation. No charge is made for the examination and transportation provided to and from the mobile examination center.



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The effective sedative, hypnotic and anti-convulsant form of Chloral Hydrate.

Also Chlorasec for quick, even sleep. DriClor inner core (equivalent to 3.75 Grs. of Chloral Hydrate). Secobarbital acid outer coat (.75 Grs.)

Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

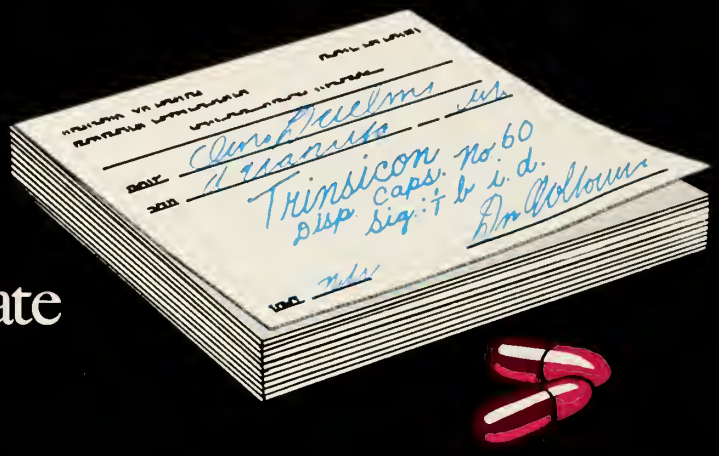
For more modern anemia therapy

Trinsicon®

Hematinic Concentrate with Intrinsic Factor

(See reverse side for prescribing information.)

Trinsicon®
Hematinic Concentrate with Intrinsic Factor



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	240 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	0.5 mg.

(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Indications: Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

Vitamin B_{12} with Intrinsic Factor—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B_{12} in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B_{12} leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B_{12}. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B_{12} deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B_{12} contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B_{12}) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

Folic Acid—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B_{12} deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B_{12} interrelationship: (1) B_{12} influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B_{12} progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B_{12}.

Iron—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

Ascorbic Acid—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

Contraindications and Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B_{12}-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B_{12} may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500 and in Identi-Dose® (unit dose medication, Lilly) in boxes of 100. [090971]

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Hematinic Concentrate with Intrinsic Factor
A Comprehensive Hematinic

Additional information available to the profession on request.

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Ohio Neonatal Program Reports Initial Progress

The Community Newborn Workshop program of the Ohio Department of Health completed its first three months of operation on June 30. Sponsors report that the program has received such enthusiastic response that it has been extended for another year.

The program was conceived early in 1972. Among persons instrumental in its development were Dr. George Shadle, director of the Division of Maternal and Child Health, Ohio Department of Health; Dr. Morris Dixon, practicing pediatrician of Wooster; and Dr. James M. Sutherland, Cincinnati, chairman of the Committee on the Fetus and Newborn, Ohio Chapter, American Academy of Pediatrics. Information on the program and activities was submitted to *The Journal* by Dr. Sutherland.

Dr. Shadle indicated that the program was addressing itself to one of the top health priorities in Ohio. Mrs. Dorothy Turner, R.N., of the Health Department's Maternal and Child Health Division, and coordinator of the program, said the workshops are stimulating phenomenal enthusiasm for improving newborn care in Ohio and have the potential for decreasing infant mortality and improving the quality of supervisorship.

Workshop faculties made up of neonatologist/nurse teams from Newborn Centers of Case Western Reserve, Ohio State, the University of Cincinnati, and Akron Children's Hospital, during the initial period, made 29 visits to 20 host hospitals over the state. Fifteen neonatologists and 17 nurses have participated. The program, up to June 30, had reached 650 to 700 people, representing 60 to 70 Ohio hospitals.

The workshop core curriculum as outlined by the Committee on the Fetus and Newborn is based on existing knowledge which when implemented can have an immediate impact on neonatal survival. The curriculum includes newborn temperature control, resuscitation, oxygen administration, and fluid and chemical balance.

Additional hospitals will be visited and plans for return visits to participating hospitals are being made. Requests for further information should be directed to:

Mrs. Dorothy Turner, R.N.
Coordinator of Neonatal Programs
Ohio Department of Health
Division of Maternal and Child Health
P.O. Box 118
Columbus 43216

The President-Elect of the Florida Medical Association, Dr. Joseph C. Von Thron, of Cocoa Beach, is a graduate of Ohio State University College of Medicine, class of 1954.

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Order Now: 1973 Models Under OSMA Auto Leasing Plan

ORDERS FOR 1973 MODELS are now being received by the Ohio State Medical Association's Auto Leasing Plan for Members. Orders for most makes and models of 1973 automobiles can be filled in approximately 30 days. The plan managers said that, while not all manufacturers' price increases have been announced, they can assure OSMA members leasing rates will increase no more than four percent, possibly less in some instances.

The plan offers leases for a 24-month period. All are closed end, which means the physician has no residual liability on completion of his lease. The physician is, however, given an option to purchase the car at the end of the lease. He is given an option price at the time he begins his leasing period.

One-year leases are available on request. In general, they are priced about 25 percent higher than the monthly rate for a 24-month lease.

All leases include Ohio license plates.

All 24-month leases are for a maximum of 40,000 miles, with a 20,000-mile maximum for a one-year lease. Excess mileage is charged at the rate of three cents a mile.

Cars are delivered F.O.B. Columbus, but will be delivered anywhere in Ohio for a flat fee of $25. The leasee is given a new car warranty card so that he may have the car serviced at the dealer of his choice.

Automobiles may be leased on an individual basis, group practice basis and by professional corporations. Cars leased under the corporate structure may be included for and driven by key personnel.

The leasing plan will help the OSMA member dispose of his present car by guaranteeing him the plan's appraisal for a period of 30 days either before or after the delivery of his newly leased car.

Insurance coverage is optional. It is available for an additional charge of $20 a month and includes $300,000-$500,000 liability, $50,000 property damage, $10,000-$20,000 uninsured motorist, $2,000 medical payments, $100 deductible collision, $50 deductible comprehensive and towing is included. **The only restriction** is that the insurance is null and void for drivers under 21 years of age.

A security deposit equal to one month's payment is required on placement of the order. First month lease payment must be paid at time of delivery.

OSMA members interested in more leasing information are invited to write or phone the OSMA Headquarters office or the administrator of the plan, Mr. Clarence Fox, Immke Circle Leasing, 32 South Fifth Street, Columbus, Ohio 43215, phone (614 228-1701).

This is the only auto leasing plan established by and approved by the Ohio State Medical Association for members of the Association.

Cincinnati Center Gets New Emergency Blood Lab

December 1 is the target date for completion of a new Emergency Procedures Laboratory — to be used primarily for prompt blood analysis — at Cincinnati General Hospital.

The new lab will adjoin the CGH Emergency Unit and will serve the entire hospital. Eventually, it will be manned 'round the clock, seven days a week, to expedite patient care.

The new facility will be an extension of the hospital's Central Laboratories. These are headed by Dr. Bruce G. MacMillan, acting director of the Department of Laboratory Medicine, University of Cincinnati College of Medicine.

UC Medical Center's major hospital treats some 345 patients in its Emergency Unit daily — including an average of four drug overdose cases. The latter requires, first and foremost, that a blood sample be drawn and analyzed to let the doctor know what drug was ingested and how to counteract it.

To speed up the process, the city of Cincinnati has awarded $50,543 worth of contracts for General Hospital's new Emergency Procedures Laboratory.

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Lorain County Medical Foundation Promotes Scholarships

The Lorain County Medical Foundation will distribute $2,700 this fall in scholarships to eight area students who are studying toward careers in medicine and other areas related to health.

Carl M. Adams, chairman of the board, announced the awards were made on the recommendation of a screening committee headed by Edward Higgins, of Amherst, following an intensive study by this committee of applications which had been received from 110 students. The grants, varying in amount for each individual, are designed to supplement resources which students already have toward their college expenses.

Presentation of the awards will be made to the students at a joint meeting of the Medical Foundation and the Lorain County Medical Society on September 12. The Foundation was originally established by the Medical Society in 1963, and is administered by a board of supervisors. A total of $22,925, representing 87 scholarships has been awarded during the nine years the foundation has existed.

The eight students who are receiving this year's awards include two in medical school, one studying osteopathic medicine, three in nursing school and two in pharmacy school.

Dr. Kenneth D. Gaver, director of the Department of Mental Health and Mental Retardation, recently announced appointments in state institutions. Dr. John J. Smith is the new superintendent of the Rollman Psychiatric Institute in Cincinnati, succeeding Dr. John T. Toppen who is returning to private practice. Dr. Fred D. Barton, of Copley, is the new superintendent of Fallsview Mental Health Center in Cuyahoga Falls, succeeding Dr. Pauline Jackson, who resigned. Dr. Albert M. Russell was named superintendent of the Massillon State Hospital to succeed Dr. Saverio Caruso, who is retiring.

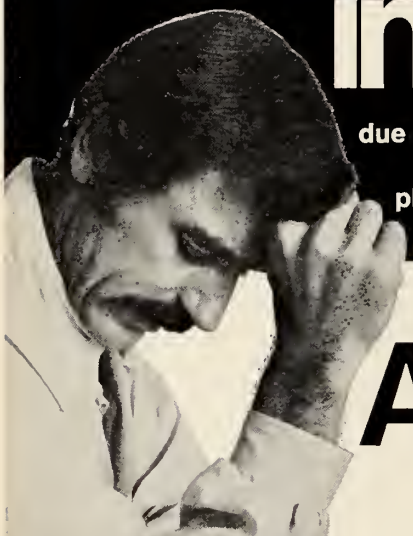
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Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected pr to and during thyroid administration.

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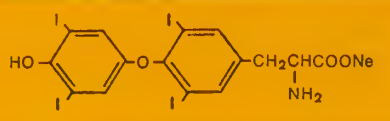
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Sodium Levothyroxine

Pharmacology: SYNTHROID (sodium levothyroxine) acts, as does endogenous thyroxine, to stimulate metabolism, growth, development and differentiation of tissues. It increases the rate of energy exchange, and increases the maturation rate of the epiphyses. Sodium levothyroxine is absorbed rapidly from the gastrointestinal tract after oral administration; following absorption, the compound becomes bound to the serum alpha globulin fraction. Accurate determination of either the PBI (protein-bound-iodine) or other appropriete tests may serve as a useful index of therapeutic response to SYNTHROID (sodium levothyroxine) therapy because of its affinity for serum proteins. The mean half-time of levothyroxine turnover is reported to be 6.5 days as measured by disappearance of radio-iodine (I^{131}) labeled levothyroxine from the serum in euthyroid subjects.

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or anti-thyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric end geriatric hypothyroidism, hypopituitary hypothyroidism, simple (non-toxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is elso indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage of SYNTHROID (sodium levothyroxine) may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting, and continued weight loss. While these effects may begin after four to five days, they may not become apparent for one to three weeks. Patients receiving the drug should therefore be kept under close observation for signs of thyrotoxicosis. If indications of overdosage eppear, the medication should be discontinued for two to six days and then resumed at e lower level. Signs of optimal thyroid function will establish the proper maintenance dose.

The severity of diabetes may be reduced by hypothyroidism, and the requirement for insulin is often lowered. Therefore, patients with diabetes mellitus should be observed closely for possible changes in insulin or other antidiabetic drug dosage requirements.

If hypothyroidism is accompanied by adrenal insufficiency, such as Addison's disease (chronic adrenocortical insufficiency), Simmond's disease (panhypopituitarism), or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The patient's progress during thyroid treatment must be observed carefully and regularly for evidence of the development of any of these conditions.

Caution must be exercised in the administration of this drug to patients with cardiovascular disease; development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Contraindications: SYNTHROID (sodium levothyroxine) therapy is contraindicated in thyrotoxicosis and acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have elso been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction in dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and administration: The importance of careful diagnosis of hypothyroidism must always be considered, despite the fact that symptomatically the condition is one of the most clear-cut of endocrine disorders. Diagnosis should include laboratory testing of basal metabolic rate, serum PBI, and other tests for thyroid function to support clinical signs of thyroid hypofunction.

Treatment of hypothyroidism requires replacement of thyroid hormone in daily amounts adequate for maintaining normal metabolism. Reliable laboratory measurements and good clinical judgment will determine the daily dose required to achieve the goal of therapy. The correct concentretion of thyroxine is essential for the health of all tissues; overdosage may lead to thyrotoxicosis medicamentosa, while underdosege permits the continuation of the hormonal deficiency.

Treatment cen be guided by the serum PBI level (the normal renge in meles is 4.5 to 7.5 mcg%; in females, 5.5 to 8.5 mcg%) produced after e few weeks by the daily dose of thyroxine administered. A PBI level below 5 mcg% may indicete the need for e larger dose of thyroxine. PBI levels ere not absolute indicetors of the thyroid state, however. In patients mede euthyroid with SYNTHROID (sodium levothyroxine), it is not unusual to find PBI levels of 8 to 10 mcg%. Levothyroxine hes e high binding capecity for serum proteins in contrest to other thyroid medicements which may contein verying amounts of L-triiodothyronine which has e low binding capacity.

In edult myxedema (when the PBI is often es low es 2.5 mcg% or less), the starting dose of SYNTHROID (sodium levothyroxine) should be 0.025 mg. daily, increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. A serum PBI, ECG, and clinical examination should be made after 30 days on this dosage regimen. In the event of an over-all repid recovery, the 0.1 mg daily dose should be continued, end the clinical status reviewed after an additional 30 days (total treatment period of approximetely 90 days). The daily dose mey then be increased to 0.2 mg. After an additional two months on this regimen, clinical and PBI evaluations should be repeated. If either appears to be below normal, the daily dose should be increased to 0.3 mg. Permanent maintenance doses vary with the individual patient, ranging from 0.1 to 1.0 mg. daily.

The same starting dose of SYNTHROID (sodium levothyroxine) as edministered for adult myxedema may be employed for cretinism or severe hypothyroidism in children, but ell intervals of chenge should be made every two weeks. In the growing child, final dosege requirements may be greater than in the adult. In cases where cretinism is discovered after the first six weeks of life, overdosage of SYNTHROID (sodium levothyroxine) therapy is much preferred to under-treatment, in order to eccelerate growth rate. As with the adult patient, serum PBI may be measured during SYNTHROID (sodium levothyroxine) administration.

In hypothyroidism without myxedema (where the PBI usually ranges from 2.5 to 4.5 mcg%), the starting dose of SYNTHROID (sodium levothyroxine) may be 0.1 mg. daily and may be increased by 0.1 mg. every 30 days. Clinicel evaluation should be made monthly end PBI measurements about every 90 days. Finel maintenance dosage will usually range from 0.2 to 0.4 mg. daily, elthough higher maintenence dosages are sometimes necessary.

In myxedematous stupor or coma, with no evidence of severe heart diseese, 200 to 400 mcg. of SYNTHROID (sodium levothyroxine) **for Injection** may be edministered intravenously utilizing a solution containing 100 mcg. per ml. Detectable effects are usually observed by the sixth hour after injection and are fully appreciated during the following day. A repeat injection of 100 to 200 mcg. may be given on the second day if significant improvement has not occurred. The intravenous use of sodium levothyroxine in myxedematous coma is adventageous because it produces a predictable increase in the concentration of protein-bound iodine, eliminates the need for multiple doses until oral therepy is reinstated, circumvents the uncertainty of oral or intramuscular absorption, and avoids the risk of pulmonary aspiration. SYNTHROID (sodium levothyroxine) **for injection** is given by the intramuscular route when the oral route is impractical and a rapid onset of effect is not desired.

It should be noted that in some patients whose PBI is 4.0 mcg% or less, endogenous secretion is reduced when exogenous thyroid hormone is administered. In these patients, the PBI does not increase as would be expected after a few weeks of medication. This may indicate the need for a longer period of observation to ascertain the required dosage. In such patients, several months may be needed to determine the correct maintenance dosage.

How supplied: SYNTHROID (sodium levothyroxine) **Tablets** are supplied as scored, color-coded compressed tablets in seven concentrations: 0.025 mg. (orange), 0.05 mg. (white), 0.1 mg. (yellow), 0.15 mg. (violet), 0.2 mg. (pink), 0.3 mg. (green), and 0.5 mg. (blue).

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Directions for reconstitution: Reconstitute the lyophilized sodium levothyroxine by aseptically adding 5 ml. of the Sodium Chloride Injection, U.S.P., to the vial. Shake viel to insure complete mixing.

Use immedietely efter reconstitution. Discard any unused portion.

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Medical College of Ohio Proceeds with Construction

The Medical College of Ohio expects to have $33.7 million worth of new buildings and services under construction or completed by June 30, 1973, it was announced recently by Howard L. Collier, MCO vice-president for administration.

This will bring the total state investment in the Medical College to $41 million, Collier said. "This is the largest single investment of state funds in northwest Ohio, and evidences the outstanding support which has been given to this region by the state to make the Medical College a reality."

Major components of this year's $33.7 million construction will take place on the new West Campus of the College: an area of 346 acres of farmland and orchards.

The buildings will include the Basic Sciences building now being completed at a project cost of $10.8 million; the Medical Library, at $7.3 million; and an Educational Support building with a project estimate of $13.3 million. Another $2.3 million has been spent for Utilities and Services for the West Campus.

When active planning for the Medical College of Ohio began in 1966, Federal funds were expected to furnish a major source of support for the state's fourth medical school. A nationwide cutback in Federal funds began before MCO could gain any benefits. The College opened its doors in temporary quarters in 1969, and the major financial responsibility was thrown upon the state.

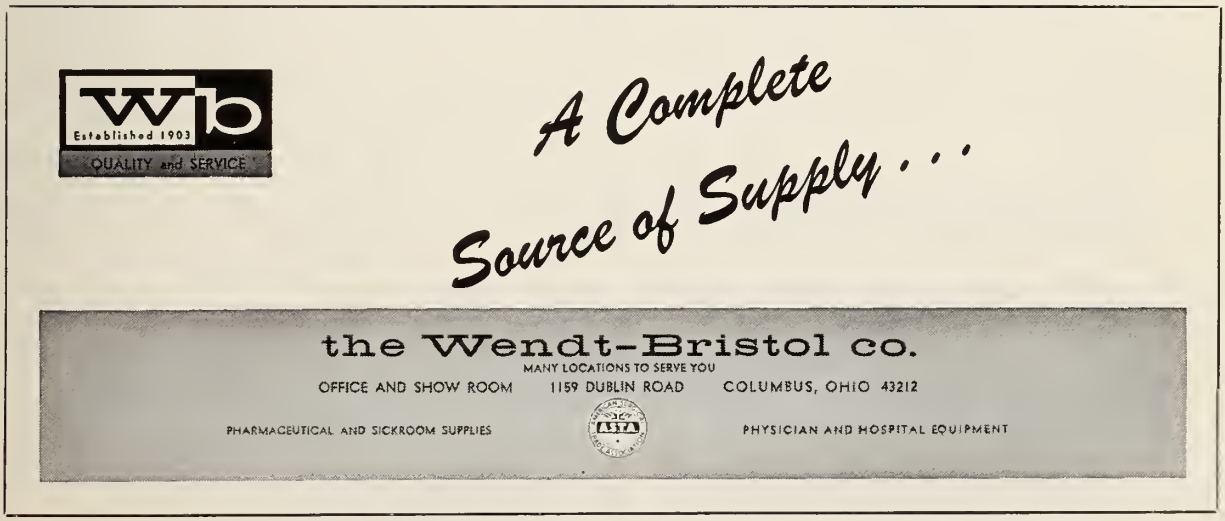
Collier and Mr. Milton Blunk, administrator of college facilities, say that bids will be opened early this fall on the MCO Medical Library, and in the spring of 1973 for the Educational Support building. Assuming the bids received come within the estimates, construction will begin on both buildings within weeks after the opening of bids.

The Basic Sciences building is under construction, and was "topped out" July 17. Blunk says the first departments can start moving in on November 27.

Completion of the Medical Library is scheduled for 22 months after start of construction; and of the Educational Support building, 24 months after the start of construction.

Vice-President Collier said, "These three buildings will complete phase one of our preclinical facilities, and will mark a major growth at MCO." As the basic science departments move to the West Campus, the clinical science departments will take over more of the current facilities on the East Campus — the former Roche Memorial and Maumee Valley Hospital complex.

The initial master plan for the West Campus included two additional buildings for clinical facilities. The MCO trustees have ordered a reexamination of this requirement to determine if it is still valid and how it will be supported.



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Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-e 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as a average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg
Postpuberal cryptorchism	30 mg

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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Continuing Medical Educational Programs of the Future

INTERNAL AND EXTERNAL pressures are now being experienced by physicians that will have dramatic impact on the future of Continuing Medical Education. Much of the internal pressure is coming from the medical community. Some state medical societies now do, or will, require Continuing Medical Education for membership. The American Academy of Family Physicians requires it and more specialty boards are considering it. The Family Practice Board requires recertification. Other groups offer rewards for participation in Continuing Medical Education.

External pressures that motivate the physician to keep up come from threats of malpractice, relicensure, public demand, and federal concern. The forces are real and great and many predict that the end result will be quality control.

Physicians desiring Continuing Medical Education today must pick from among thousands of offerings and weigh cost and time against the often unknown benefits. Continuing Medical Education activities of the future therefore must be based on offering the physician an attractive and reasonable approach.

Building Meaningful Continuing Medical Education Programs of the Future

First, physicians must be provided opportunities for identifying the type of medical care they most often provide and the diseases and problems they most often encounter. **Second,** physicians must be given opportunities for identifying their needs either by self-assessment tests or a review of problem-oriented records. **Third,** physicians must be given opportunities for setting objectives for Continuing Medical Education activities which will strengthen their weaknesses. **Fourth,** physicians must be provided with a variety of educational opportunities to fulfill their objectives.

William G. Pace, III, M.D.
Director, Center for Continuing Medical Education, College of Medicine, The Ohio State University

John C. Barton, Ph.D.
Research and Development Specialist, Center for Research and Development in Vocational and Technical Education, The Ohio State University

Characteristics of Future Continuing Medical Education Programs

If physicians are involved in planning their continuing medical education programs, then, programs of the future will take on new and different formats.

1. Continuing Medical Education programs will be based upon practical felt needs of physicians.

2. Continuing Medical Education programs will be cooperatively planned involving medical center faculty, practicing physicians and adult educators.

3. Larger audiences will attend future Continuing Medical Education programs because of their pragmatic design.

4. The community hospital will become the base for Continuing Medical Education with the university medical center becoming an important source of research findings.

5. Faculty for future Continuing Medical Education programs will come in larger and larger numbers from the ranks of practicing physicians.

6. More Continuing Medical Education programs will be conducted on weekends to capitalize on "free time" of physicians.

7. Educational methods and techniques utilized in Continuing Medical Education programs will change from mass instruction to more individual instruction. Techniques that will be used include:

   a. Computer Assisted Instruction
   b. Programmed Instruction
   c. Medical T.V.
   d. Video tapes
   e. Preceptorships
   f. Medical radio

8. Programs covering one or two topics will be more in evidence than programs covering many topics.

9. Agencies in free enterprise will be involved in Continuing Medical Education in

competition with medical centers and community hospitals.

Since the time and resources available for providing continuing education opportunities for physicians are limited it is imperative that future efforts be focused upon the important elements of professional practice and conducted with the highest achievable level of educational efficiency. It is also imperative that future efforts in continuing medical education reflect the needs of the learners and utilize methods and techniques that are appealing to the physicians. Real progress cannot be made in continuing medical education until problems of medical care are carefully identified and physicians themselves are given the opportunity to share in the process that will disclose the dimensions of the problem.

Medical Center at Gallipolis Reports on Emergency Work

Holzer Medical Center at Gallipolis treated 1,414 patients in the emergency room at the new facility during June, the first full month of operation. See August issue of *The Journal*, page 764. for a report of the opening.

Accident victims accounted for 492 of these cases with 59 traffic accident cases, 85 recreational accidents, 140 industrial accidents, and 208 home accidents.

Of the 1,414 patients seen, 1,111 were sent home from the emergency room. 43 returned to work, 11 were transferred to another medical institution, and 245 were admitted to Holzer Medical Center.

During the month two cases were dead-on-arrival at the emergency room and two more died while in emergency. At the new building, emergency is separated from patient floors and examining rooms and an accurate count can be maintained.

The U.S. Department of Health, Education and Welfare announced in June that the first federal grant to a state for prevention, treatment, education, and rehabilitation programs to deal with alcohol abuse and alcoholism had been made to Texas. The $1,631,247 grant was awarded by the new National Institute on Alcohol Abuse and Alcoholism (NIAAA). The state agency in Texas is the Texas Commission on Alcoholism.

Pre-Sate ®
(chlorphentermine HCl)
CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
Full information available on request.

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P-21-B/W

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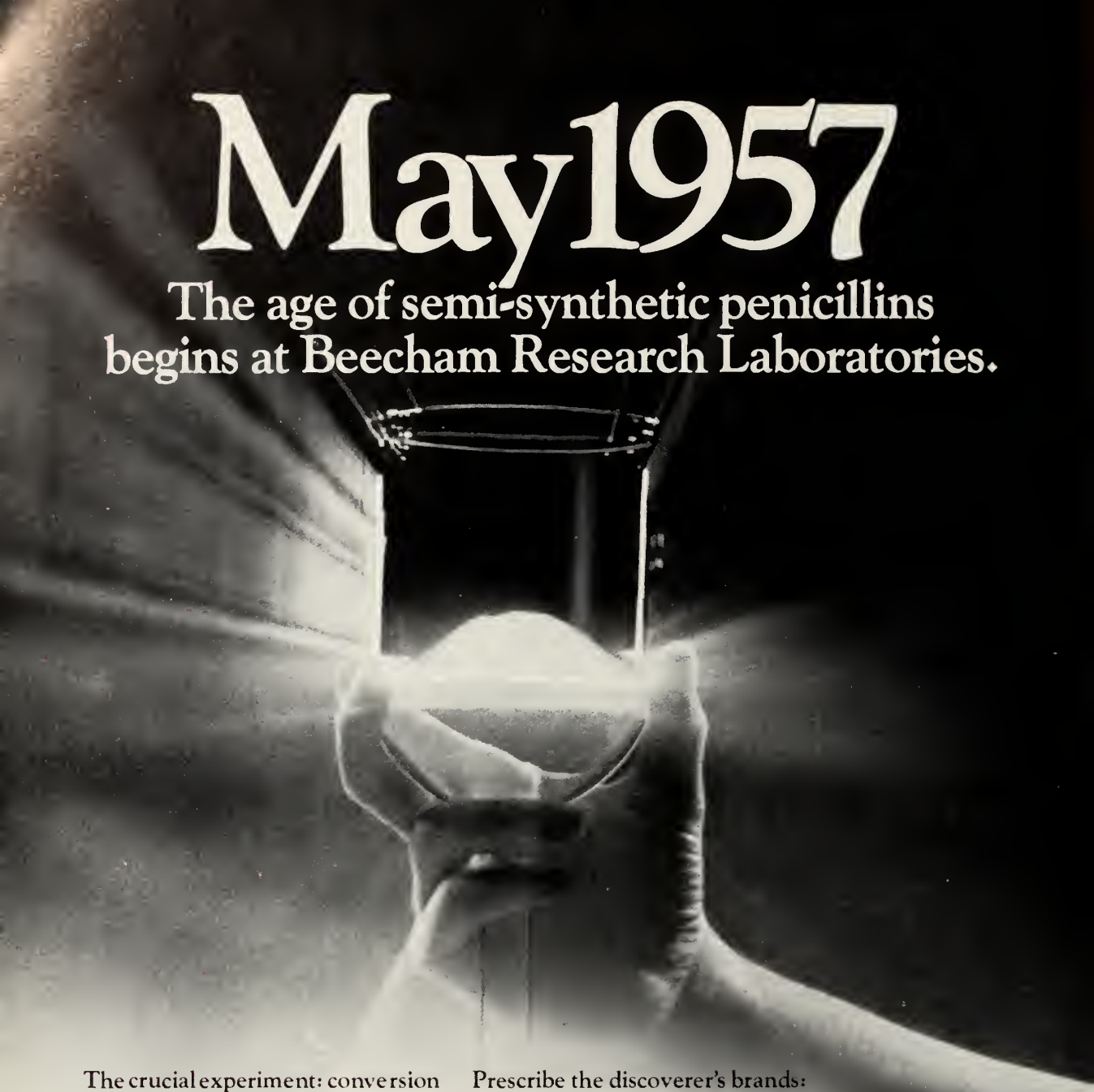
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May 1957

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☐Totacillin (ampicillin trihydrate) capsules equivalent to 250 mg. and 500 mg. ampicillin, for oral suspension equivalent to 125 mg./5 cc. and 250 mg./5 cc. ampicillin. ☐Pyopen (disodium carbenicillin) vials for injection equivalent to 1 gm. and 5 gm. of carbenicillin. ☐Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.

Blood Donors Will Be Screened for Hepatitis

In a communication to health commissioners of Ohio issued July 28, John W. Cashman, M.D., director of the Ohio Department of Health, quoted the following teletype message from the Food and Drug Administration:

"The Food and Drug Administration issued the following press release on Hepatitis Serum for release Friday A.M., July 28, 1972:

"A significant decrease in Post Transfusion Hepatitis, a disease which causes 1,500 to 3,000 deaths annually in this country, is expected to result from two recent actions by the Food and Drug Administration's Bureau of Biologics.

"The first action, effective July 1, 1972, is a requirement that all Federally licensed blood banks must test each donor for the presence in his blood of the Hepatitis Antigen (the so-called HAA factor). Only if the donor's blood tests negative can it be accepted for transfusion. About 85 percent of blood collections in the U.S. are through Federally licensed facilities.

"The second action, to be announced in the Federal Register of July 28, 1972, is FDA licensure of a new Hepatitis test procedure far more effective than the tests now available. The new test was developed and introduced by Abbott Laboratories, Chicago.

"In announcing the licensing of Abbott's new test, FDA's Bureau of Biologics Director, Harry M. Meyer, Jr., stated: 'It is apparent that the use of this new technique, extensively tested by the Bureau, will significantly increase the detection of units of blood harboring the Hepatitis virus.'

"Previously licensed tests have been capable of detecting only 20-25 percent of the bloods implicated in causing Post Transfusion Hepatitis.

" 'Prior to the Hepatitis test — all developed within the past two years — there was no practical way of demonstrating the virus in whole blood or blood products. The only means of identifying possibly infected donors was on the basis of a clinical history of Hepatitis,' Dr. Meyer stated.

"S/Glenn V. Kilpatrick, Director, Division of Federal-State Relations, Office of the Executive Director of Regional Operations."

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Who's standing up for your rights? Contrary to what you may think, the AMA.

We've testified repeatedly against a government controlled medical system. Even before it was proposed, the AMA had introduced its own program of voluntary national health insurance called "Medicredit." And we've pushed for it hard. To date, the AMA has enlisted 167 members of Congress as its co-sponsors—more than can be claimed for any other national health insurance bill.

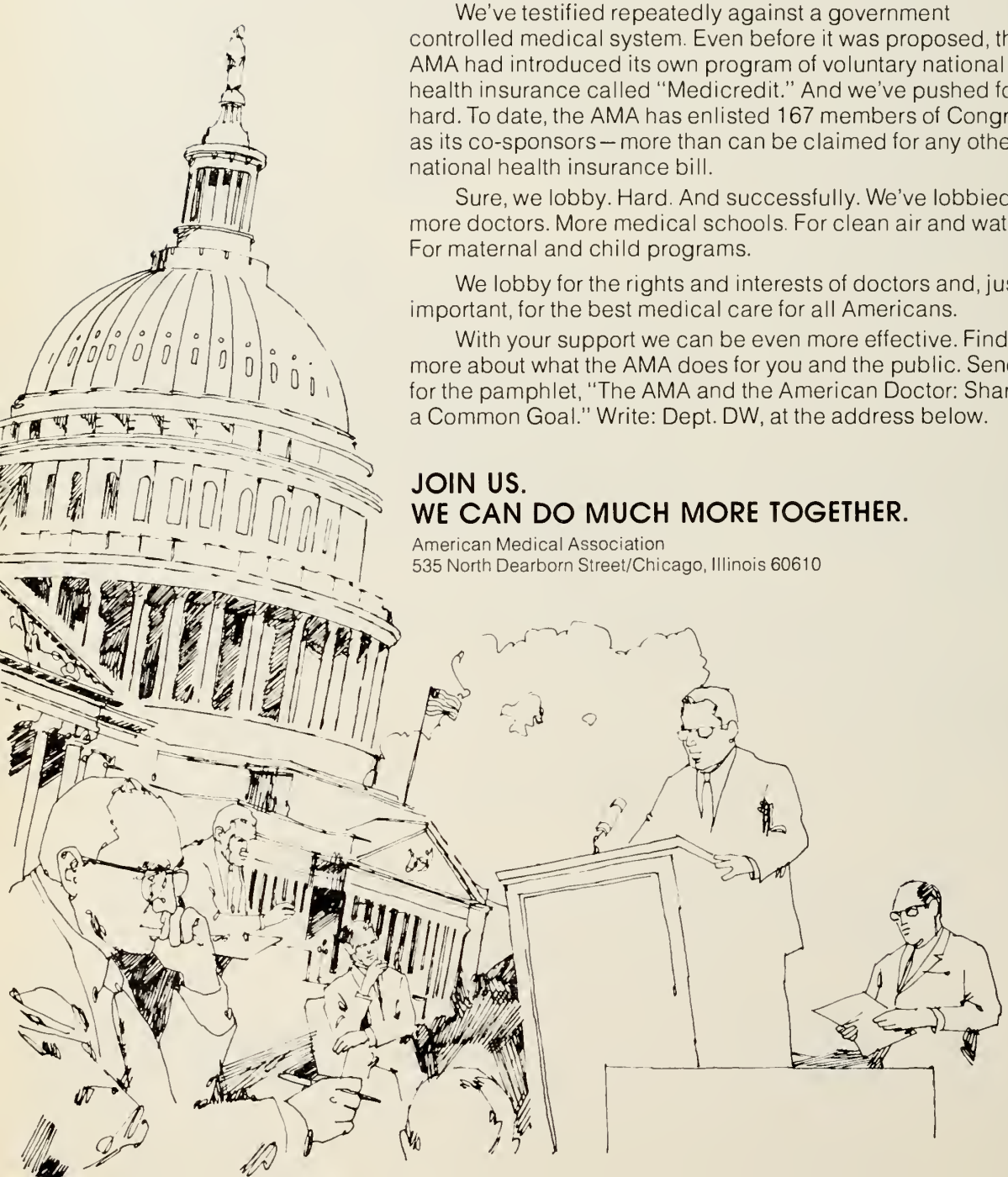
Sure, we lobby. Hard. And successfully. We've lobbied for more doctors. More medical schools. For clean air and water. For maternal and child programs.

We lobby for the rights and interests of doctors and, just as important, for the best medical care for all Americans.

With your support we can be even more effective. Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

JOIN US.
WE CAN DO MUCH MORE TOGETHER.

American Medical Association
535 North Dearborn Street/Chicago, Illinois 60610



Continuing Education Opportunities for Physicians in Ohio

September

Aging Conference, University of Cincinnati Medical Center (CONMED), at Good Samaritan Hospital, September 12.

Physical Diagnosis for the Practitioner, Akron City Hospital, 525 E. Market Street, September 13, beginning at 8:30 a.m.; Thomas R. Riley, M.D., and Raymond S. Federman, M.D., coordinators.

Infections in Obstetrics and Gynecology — Sponsored by the Cleveland Society of Obstetricians and Gynecologists in the Bunts Auditorium of the Cleveland Clinic, 3:00 p.m., September 13; William Ledger, M.D., of the University of Michigan, guest speaker; contact Kathryn Hoffman, M.D., 806 Rose Building, Cleveland 44115.

Symposium on Clinical Aspects of Placental Insufficiency, sponsored by the American College of Obstetricians and Gynecologists, Cleveland, September 30; contact Silvio Aladjem, M.D., Department of Obstetrics and Gynecology, University Hospitals, Cleveland 44106.

October

Care of Newborn Infants, University of Cincinnati Medical Center (CONMED), October 4.

Pediatric Postgraduate Conference, Ohio State University College of Medicine, October 4-5.

Group Psychotherapy, Ohio State University, October 6 through December 22 (26 hours).

Chronic Otitis Media in Children, Ohio State University College of Medicine, October 7.

Annual Cancer Symposium sponsored by the American Cancer Society, at Scot's Inn Motel, Columbus, October 11, 9:00 a.m. to 4:00 p.m. Contact, American Cancer Society, Ohio Division, 1367 East Sixth Street, Cleveland 44114.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

An Introduction to Transactional Analysis, Akron City Hospital, 525 E. Market Street, October 11, beginning at 8:30 a.m.; Thomas R. Riley, M.D., and Raymond S. Federman, M.D., coordinators.

Tri-State Regional Meeting (including Ohio), American College of Physicians, October 13-14, Motel Heart of Town, Charleston, W. Va.; contact Jack D. Baur, M.D., 1115 20th Street, Huntington, W.Va. 25703.

Rheumatoid Arthritis, University of Cincinnati Medical Center, (CONMED), October 19-20.

Association of Physicians of the State of Ohio, quarterly meeting, October 20, Juvenile Diagnostic Center, Columbus; contact Virginia Edwards, M.D., 374 Lexington Avenue, Mansfield 44907.

Diabetes Seminar, Ohio State University College of Medicine, October 25.

Current Therapy III — Infectious Diseases — Third Annual Postgraduate Medical Seminar sponsored by the Scioto County Medical Society; Thursday, October 26, at the American Legion Hall, 705 Court Street, Portsmouth.

Psychotherapy of Adolescents, Ohio State University College of Medicine, October 27-28.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA
Yoon Ho Pyo
Cleveland

COLUMBIANA
Itikala S. Rao
Salem

FRANKLIN (Columbus)
William Scott Bolz
Robert J. Fass
Lorence A. Gutterman
Albert J. Hart, Jr.
Larry L. Heller
Myron E. Moorehead
Stewart F. Stock
Alan G. Weinberg

FULTON
Bernard B. Cohen
Wauseon

HAMILTON (Cincinnati)
Solomon E. Erulkar
Allen Rae Shade
Robert E. Weinstein
Frederick B. Winston

LUCAS (Toledo)
Dong Hae Lee
Oktay Mete
Aquiles Palma-Gil
Teresita Palma-Gil
Robert P. Plosscowe

MAHONING (Youngstown)
Abdul Hafiz
Hyon Sang Hwang
Parviz Soleimani

MEDINA
Graciano B. Dichoso
Lodi

SUMMIT
Rong-Sen Hsieh
Barberton
Vembar V. Sreenivasan
Akron

VA Undertakes Study in High Blood Pressure

The Veterans Administration has responded to the call issued at the National Conference of the Status of Health in the Black Community by undertaking "in depth screening" for high blood pressure among patients.

Dr. Howard W. Kenney, director of VA's 13-state New England and Northeastern Medical Region, pointed out that high blood pressure and the resulting strokes and heart attacks are the main health problem of the black community.

Between the ages 25-44 years, high blood pressure kills 15.5 times as many black males as whites and 17 times as many black females, he said.

The Conference, held at Meharry Medical College in Nashville, Tenn., urged nationwide screening for early detection of those with high blood pressure and better treatment of this disease by the medical profession generally, Dr. Kenney said.

Sixteen VA hospitals are starting in depth screening and follow-up of all their patients for hypertension, and other VA hospitals will join the program as experience is gained.

What to Write for

Living with Blindness. This pamphlet is written by a lay writer for lay people who are associated with the blind. One of many pamphlets published by Public Affairs Pamphlets, 381 Park Ave., South, New York, N. Y. 10016; pamphlet No. 473; price 25 cents.



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GUY H. WILLIAMS, Jr., M.D. Medical Director
G. PAULINE WELLS, R.N. Admin. Director
HERBERT A. SIHLER, Jr. President
MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals

"The history of science, and in particular the history of medicine...is... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

—George Sarton, from "The History of Medicine Versus the History of Art"

Would it be useful in clinical practice to have government predetermine drugs of choice?

Opinion

Results of a survey of physicians:

13.3%
Yes, it would be useful.

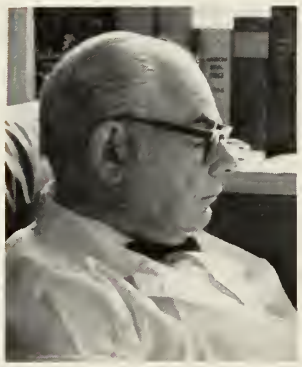
86.7%
No, it would not be useful.

Dialogue

Would it be useful in clinical practice to have government predetermine drugs of choice?

Doctor of Medicine

Walter Modell, M.D.,
Professor of Pharmacology,
Cornell University
Medical College,
Editor,
Clinical Pharmacology
& Therapeutics,
Drugs of Choice,
Rational Drug Therapy



The proposition that government should determine one or two "drugs of choice" within a given therapeutic class reflects the belief that a similarity in molecular structure insures a close similarity in pharmacologic effect. But this is by no means the rule. An obvious example would be in the field of diuretics, where a small change in chemical structure accounts for substantial differences in concomitant effects such as potassium excretion.

Any attempt to dictate the "drug of choice" would be complicated by the fact that some populations demonstrate a bimodal distribution in their reaction to drugs. If the data on drug response are mixed for the total population, one drug will appear to be as useful as the other. But if drug response is reported separately for different segments of the population, drug A will be found to be better for one group and drug B for the other.

It may, of course, be possible to determine drugs of choice in particular categories on a broad statistical basis. But there are always certain patients in whom a drug produces odd, unpredictable or idiosyncratic reactions. So, though a drug might statistically be the most useful one in a given situation, individual variations in response might make it the *incorrect* one.

The point I wish to make is that if two, three, four or more drugs in one class are of approximately equal merit, that in itself is justification for their availability. Exceptional cases do arise in which one drug would be useful to a certain segment of the population and another drug would be of no use at all. In the practice of medicine, the physician must be prepared to treat the routine as well as the unusual case.

Another objection to the determination of a drug of choice is that precise statements of *relative* efficacy are very difficult to make—much more difficult than statements of efficacy. For example, in testing drug efficacy, it is easy to determine the difference between a drug that is effective in treating a condition and one that is not at all effective. Thus, it is fairly easy to determine whether a drug is more effective than a placebo. But if you compare one drug that is effective with another drug that is also effective, and the relative differences between them are very slight, statements of relative efficacy may be very difficult to make with assurance.

I do not mean to imply that relative efficacy statements are not useful or can never be made. With some groups of drugs (e.g., analgesics), extensive study and precise methodology have yielded useful information on relative efficacy. But in most situations, such information can be acquired only through studies encompassing three to five years of use in many more patients than are used to compare drugs with a placebo for the introduction of a drug into commerce. It is really only after practitioners use a drug extensively that relative safety and efficacy in practice can really determined.

The Bureau of Drugs h suggested the package sert as a possible means communicating informat on relative efficacy of dr to the physician. I find t objectionable, since I not believe the physic should have to rely on t source for final scient truth. There is also a pr tical objection: Since f physicians actually d pense drugs, they seld see the package insert. any event, I would ma tain that the physici should know what drug wants and why without pending on the governm or the manufacturer to him.

Undoubtedly, physici are swamped by excess numbers of drugs in sc therapeutic categories. I am well aware that ma drugs within such ca gories could be elimina without any loss, or haps even some profit the practice of medic But, in my opinion, neit the FDA nor any ot single group has the exp tise and the wisdom ne sary to determine the "drug of choice" in areas of medical practic

Maker of Medicine

eth G. Kohlstaedt, M.D.,
Vice President,
Medical Research,
li Lilly and Company



my opinion, it is not unction of any governet or private regulatory cy to designate a "drug oice." This determinashould be made by the ician after he has red full information on properties of a drug, then it will be based on experience with this and his knowledge of individual patient who eking treatment.

an evaluation of comtive efficacy were to be e, particularly by govnent, at the time a new is being approved for keting, it would be a t disservice to medi- and thus to the patient e consumer. For exam- when a new therapeugent is introduced, on basis of limited knowl-, it may be considered e more potent, more ctive, or safer than ducts already on the ket. Conceivably, at time the new drug d be labeled "the drug hoice." But as addial clinical experience is mulated, new evidence become available. r, it may be apparent that the established products should not be so easily dismissed.

Variation in patient response to drugs constitutes one of the major obstacles to the determination of "drugs of choice." We are just beginning to open the door on pharmacogenetics, but it is evident that genetic differences cause wide variations in the way drugs are absorbed, metabolized, etc. This fact alone is sufficient to make unrealistic the idea that there is one drug in each class to be used for every human being.

The problem of determining relative drug efficacy is an extremely complicated one. Comparison with other drugs of the same class should not be a prerequisite for marketing a new substance. In some therapeutic areas, it may be difficult to make accurate comparisons. For example, in the treatment of infections it is not possible to conduct crossover studies. Recovery may be influenced by factors which cannot be controlled or measured, i.e., natural host resistance and virulence of infective agents. A drug's acceptability must often be judged on the basis of its own performance, and this may be limited to experience in a relatively small patient population. If the introduction of a new drug must await the adequate establishment of relative efficacy, the duration of clinical trial and extent of studies would be greatly prolonged, particularly for rare or unusual conditions. The availability of a new drug would be delayed. Many patients might suffer needlessly and lives might be lost.

Relative efficacy can best be established by experience in a general patient population through regular channels of clinical practice. The physician considers the patient as a whole, which means the patient often has multiple problems and drugs must be selected with this in mind. Hence, a "drug of choice" in an uncomplicated case may not be the best drug for a patient with associated problems. Publication of well-controlled studies in medical journals may provide comparative evidence; discussions at medical meetings, presentations at postgraduate courses, and the new audiovisual technology may bring evidence to physicians on comparative therapy. In a free medical marketplace, a drug that does not measure up will fall into disuse. For example, broad clinical experience has established vitamin B_{12} as the "drug of choice" for the treatment of primary pernicious anemia. No amount of advertising or promotional effort by the manufacturer could increase the use of liver extract for this anemia. However, a physician may wish to employ parenteral liver preparations for a special purpose.

In the field of surgery, peer review in the hospital has brought significant improvement in the use of new techniques and procedures. Something of this nature would be useful in the area of drug therapy. However, it should be developed by the medical profession itself and would necessitate, for its proper function, an improvement in the dissemination of reliable data on clinical pharmacology of drugs under consideration.

Ideally, information on the relative efficacy of drugs should be gathered and assessed by the physicians who actually administer the specific agents to a specific patient population. To do this, they will need even more information on the drugs they use – information that the pharmaceutical manufacturers must begin to provide if government regulation of *"drugs of choice"* is to be avoided.

Opinion & Dialogue

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Clinical & Scientific Features



VOLUME 68 SEPTEMBER 1972 NUMBER 9

Hay Fever

Discussion of an Approach to More Comprehensive Treatment

JOHN T. BICKMORE, M.D.

ANY MALADY which affects millions of people, year after year, during the most productive years of their lives, deserves serious consideration by those who are attempting to treat it. Although the mortality is low, the morbidity of hay fever, or ragweed pollinosis, is tremendous, and a more comprehensive program of management is needed for these sufferers. Many have gone through a series of "shots" year after year without appreciable relief, until disillusioned, they eventually abandon supervised medical treatment. Some then attempt to suffer through the season without help. A few become "nose drop addicts." Others fall into the more dangerous error of self-medication, indiscriminately taking several drugs, including the powerful steroids, without regard to the dangers of incompatibility or side effects.

As generally practiced, the treatment of hay fever often lacks completeness because it is seldom recognized that (1) many factors other than ragweed pollen play a significant role in this illness; (2) variations in degree of sensitivity is the rule rather than the exception, which makes standardized dosage ineffective; (3) the optimum desensitizing dosage of antigens may need to be determined repeatedly; and (4) the patient himself must be educated toward other factors that influence his illness.

During the life of most allergic individuals more and more sensitivities slowly but inexorably develop. In most instances, multiple sensitivities have been established by the time misery is sufficient to drive the patient to a physician for help.

Submitted December 7, 1971.

The Author

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Seldom is a patient encountered who is sensitive only to ragweed.

Therefore, it behooves the investigating physician to be familiar with all the indigenous plants which throw off large amounts of pollen in the region, and to know just what season they are likely to be active. In addition to both giant and short ragweed, certain grasses, pigweed, kochia, the chenopodia, thistles, cocklebur, hemp, dock, plantain, marsh elder, and sage may be exuding pollen in a given locality. The contributing effects of secondary pollens such as these, particularly those which peak at about the same time as ragweed, cannot be ignored.

When offending pollens have been identified, two courses of action are open to the patient: total avoidance or desensitization. A sojourn into an area free of the offending pollens may be possible to some, and spending most of the pollen season in an air-conditioned, air-filtered environment may be practical for others, but the majority will require desensitization to obtain relief. Desensitization is accomplished by administering optimum dosage of the allergen at optimum intervals.

Consider Variations Which Affect Plans for Desensitization

A standard or "average" dose of an identified pollen is unsatisfactory, if not impossible, because of multiple factors that may be involved and variations therein.

First, there is the variation in individual sensitivity. A dose that brings relief to one patient may be either too weak to be effective or too strong to be tolerated by another patient. Therefore, a method of determining individual response is imperative in determining optimum dosage. Second, during the ragweed season the same individual may vary in degree of sensitivity. According to Willoughby,[1] approximately nine out of ten allergic patients will alter in their degree of sensitivity at some time during the season. If so, then only 10 percent would be relieved by a standard, uniform injection of antigen. Rinkel and Williams[2] found that out of every 100 patients treated, 43 percent became less sensitive, 21 percent became more sensitive, and 36 percent maintained a steady degree of sensitivity, despite treatment. For the changes noted, Williams[3] blamed the fluctuating amounts of pollen in the air, concomitant sensitization to other pollens, food sensitization, and infection.

Variations in Pollen Count

Variations in pollen count may dictate variation in dosage. Preseasonal growing factors, particularly the amount of rainfall, can affect total seasonal output of pollen. Seasonal weather factors, such as prevailing wind direction and how recently rain has "washed" the air, influence the amount of pollen in the air at any given time. Difficulties in determining dosage are always encountered during the early season of ragweed, when counts are mounting rapidly, and fluctuate widely from day to day.

Atmospheric Molds

Atmospheric molds peak at about the same time as does ragweed. If the patient is sensitive to one or more of these molds, their desensitization must be included in any treatment of hay fever. Identification of individual molds is time-consuming and difficult, but it can be done. Extracts of the major molds *(Alternaria, Hormodendrum and Cephalosporium)* are available for use in desensitization and are titrated individually. There are probably more than 45 lesser molds of clinical importance. Extracts of these have been combined into mixes to be used for the same purpose.[4]

Nature has been most unspecific in the overlapping of pollen and mold seasons. The time and duration of these seasons depends upon locale and climate. In southwestern Ohio, for example, the grass pollinating season (time of year when the offending substance is present in greatest abundance in the atmosphere) is largely over by the end of July, but this is not always true for all species of native grasses. In Texas, grass pollinates in all months of the year except midwinter. In Florida, the grass, weed, and mold seasons are all long, and are not at all specific. In the Midwest, molds reach their peak in late summer, just about coinciding with ragweed; however, the first frost kills ragweed, while the molds persist considerably longer.

Dietary Allergies

Food allergies are the least understood and the most difficult to detect and treat in all the realm of allergic investigation, but their importance, nevertheless, must be considered. The majority of allergic patients are sensitive to one or more foods. These cannot be ingested without producing discomfort to either the "shock" organ or to some other system. A food, which may be a minor antigen, thus often complicates the response to a major antigen, such as pollen, dust, mold, or animal dander. Therefore, existing food allergies should be sought for and eliminated from the diet if maximal relief from the fall hay fever syndrome is to be obtained.

In our experience, a rotary diversified diet[5] has been helpful in identifying foods to which the

patient might be sensitive and in reducing the incidence of food sensitization, and it is taught to all of the patients whose allergies are difficult to control. This diet is based on the principle, first advanced by Rinkel,[6] that avoidance of a food leads to tolerance of it, and that the repetitive ingestion of a food enhances its sensitivity. The main staples of the diet, meat, vegetables and fruit are to be eaten, but rotated, so that beef, for example, is eaten only once on every third or fourth day. All foods are diversified as much as possible, and cooked simply, without gravies, sauces, etc. Wheat, corn, and dairy products are greatly reduced, and snacking is discouraged, because the patient may crave that very food which affects him most. This regimen is continued until clinical relief is obtained or until the offending food or foods are identified. For more complicated cases more severely restricted diets are enforced for short periods, adding one food group at a time until symptoms are exacerbated. The provocative food test, developed by Rinkel[7] and Lee,[8] can be used to confirm identification when individual foods are suspected.

To recapitulate, in comprehensive treatment of hay fever, it is necessary first to identify the atmospheric antigens to which the patient is sensitive, and though the prime suspect is ragweed, it may be supplemented and potentiated by a wide variety of other atmospheric and household allergens, and by the ingestion of certain foods. The patient can be taught to avoid some of these allergens; others, being unavoidable, will require desensitization. After as many allergens as possible have been identified, it is then necessary to determine the optimum dose for desensitization of each incriminated allergen. This dosage will not only differ from individual to individual, but will also differ from time to time in the same individual, due to factors already discussed.

Serial Dilution Titration

In our experience, a satisfactory approach to these problems begins with serial dilution titration of the skin to determine the relative sensitivity for each suspected inhalant allergen known to exist in the area where the patient lives and works. Serial dilution titration not only determines this degree of sensitivity, but also indicates the dilution at which treatment can be instigated safely and within a close therapeutic range. It does not indicate the dosage of the antigen that will give maximal relief for an optimum time.[9] The optimum dosage is determined by the effect on symptoms and the onset and duration of relief.[10] Guided by serial dilution titration of the skin, and observing the progressive increment in wheal size as stronger and stronger dilutions are placed, a correct "end point" is determined. If this end point is indicative, and appropriate dosage administered, symptoms subside quickly, often within the hour. An accurate judge of success in pollen treatment is relief of the ocular itching. The patient is the arbiter of dosage interval, ie, when his symptoms recur, he should return for another injection. In mid-ragweed season the severely sensitive patient may require injection every 48 hours. Secondary pollens, dusts, and molds rarely require such frequent injection.

Patterns of Desensitization

Three types of treatment patterns develop: coseasonal, preseasonal, and perennial. *Coseasonal* desensitization refers to treatment given only during the season when the allergen is most abundant. This suffices for the mild cases when the patient has low sensitivity to weed pollen, few secondary sensitivities, and no significant food allergies. *Preseasonal* desensitization treatment begins before the expected time of greatest abundance of the principal allergen, with retitration to determine shifts in sensitivity and injections to build up immunity before the season actually begins. This is required for the intermediate group of sufferers. *Perennial* desensitization treatment continues the year around to provide relief and some degree of protection to those who have multiple and long-standing sensitivities. Since patients who are highly sensitive to ragweed tend also to be sensitive to many other pollens, and this tendency inexorably spreads into sensitivities to many other allergens, they become the patients who so often complain of "sinus" or of "constant colds," and have respiratory symptoms in all seasons. Ragweed sensitivity is only a part of their illness, even though they first appear in the physician's office during the ragweed season, complaining of hay fever. These perennial sufferers often have frequent headaches, recurring cough, urticaria, or eczema, and many vague gastrointestinal complaints. Some have recurring asthma attacks. Their difficulties are caused by multiple allergies.

Unless adequately controlled, many of these perennial sufferers will lapse eventually into asthmatic bronchitis, nasal polyposis, or chronic upper respiratory symptoms caused by superimposed sinus infections. If questioned carefully, these patients will often give clues which indicate that their allergies have been developing since early childhood.

Desensitization treatment requires at least monthly booster shots of all the antigens to which sensitivity is proven, even though not in season, plus more frequent injections of the antigens which are in season. Each visit provides the physician with an opportunity of further developing the patient's history, which is seldom exact or complete. All food idiosyncrasies, chemical susceptibili-

ties, and other sensitivities must eventually be investigated and evaluated.

Drug Therapy

The use of adjuvant drugs is recommended as supportive therapy to control symptoms, and only when the side effects are not excessive. Antihistamines, with or without vasopressors are generally indicated, though they fail to relieve asthma. Corticosteroids should be used with caution and only for temporary control of symptoms when the pollen season is violent and distress is severe. Steroids suppress symptoms without reducing sensitivity and also tend to distort the results of titration. A single injection of corticosteroid at the beginning of the hay fever season is not harmful, and often causes a dramatic reduction of symptoms. However, steroids are not recommended for sole routine use in the treatment of hay fever.

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* * *

E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

A 10-year-old boy presents with the history of unilateral nasal obstruction and nose bleeds of increasing severity.

Physical examination is not remarkable except for a dark-red lobulated mass in the left naris (Fig. 1). Examination with a nasopharyngeal mirror reveals the lesion also to be present in his nasopharynx.

Radiographic examination showed a clouding of the right maxillary sinus and naris.

What is your diagnosis and next step in evaluation?

(See p. 857 of this issue for further information and discussion.)



Fig. 1. Dark-red lobulated mass is seen protruding from left naris.

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Submitted February 28, 1972.

Comparison of Three Agents Used in Surgical Scrubs

Herbert A. Giese, Jr., M.D., M.P.H., and Ann Wickline, R.N.

SINCE THE TIME that Semmelweis introduced chlorinated water for hand washing in the Vienna General Hospital and demonstrated a decrease in the incidence of puerperal sepsis, a better, more acceptable means of achieving asepsis of the hands has been sought. Today, the generally accepted technic is to use an antiseptic detergent, warm water, and a scrub brush. The detergent, water, and scrub brush are applied vigorously for a prescribed time, usually 7 to 10 minutes, and then the hands and arms are rinsed in water, dried, and gloved.

The Authors

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Materials and Methods

The purpose of this study was: (1) to compare three hexachlorophene-containing agents used for surgical scrubs, and (2) to compare surgical scrub technic with these agents to the surgical hand wash technic with the same agents, materials, and methods. Three hexachlorophene-containing agents were used: (1) pHisoHex antibacterial detergent with 3 percent hexachlorophene in suspension; (2) Gamophen leaves, a dry detergent preparation with 6 percent hexachlorophene in the dry state, and (3) MD-7, a nondetergent soap with 1 percent hexachlorophene in the form of a powder.

Ten surgical technicians were divided into two groups. Each member used the same agent during the week, Monday through Thursday. One of the groups used a surgical scrub technic with the brush method, and the other group used a surgical hand wash technic. Each participant brush scrubbed or hand washed for exactly seven minutes initially and then for three minutes before subsequent procedures during the day. After drying the hands and before gloving, the tips of four fingers of the right hand were imprinted onto one-half of a blood Agar plate (Table 1). Immediately after the case and immediately after degloving, the four fingertips of the left hand were imprinted on the second half of the blood Agar plate. The plates were incubated for 24 hours at 37 C and a colony count was made of each one-half of the blood Agar plate and was reported (Table 2). The two groups alternated with each new agent used. One group used the brush scrub for that four-day period and the other group hand washed. The two groups then switched procedures for the next agent. The colony counts on the blood

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Agar plates were placed into two categories — low colony count, 50 or fewer colonies per one-half of plate, high colony count, 51 or more colonies per one-half of the blood Agar plate.

Results

Hands washed or scrubbed with pHisoHex demonstrated more low colony counts than did Gamophen or MD-7, both before and after the procedure ($p=0.05$). There was no significant difference between colony counts of the hands that were brush scrubbed and the hands that were washed with pHisoHex, but the brush scrub with MD-7 did yield more low colony counts. That, however, did not reach a level of significant difference (Tables 3 and 4). It should be noted that one of the five surgical technicians of the brush-scrubbing group was excluded from the study because of dermatitis, which developed during scrubbing with pHisoHex, and one of the five was excluded while using Gamophen for the same reason. No dermatitis occurred in the technician who used the hand washing technic.

Discussion

Price has pointed out that in addition to the surface bacteria, there is a reservoir of bacteria deep in the skin.[1] Superficial bacteria come off at a regular rate, and the deeper bacteria begin to appear in appreciable numbers after several minutes of scrubbing. The deep flora appeared to have the same composition as the superficial flora.[2] Richards found these organisms regrow immediately and replace themselves by 25 percent in 24 hours and 73 percent in three days.[3] All cutaneous surfaces carry potentially infectious bacteria. Most of the transients can be readily removed by soap and water. The remaining flora are best attacked by a suitable antiseptic agent. Many feel the only way of achieving this goal is by the agent applied vigorously with a harsh brush scrub. Walter and Kundsin demonstrated that dermatitic skin consistently yielded high counts. Scrubbing was not effective in lowering the bacterial counts of these individuals.[4] In our study only the scrubbing technicians developed any dermatitis, but otherwise there was no difference in the disinfecting capacity of the scrub and the hand wash. Repeated two-minute hand washings with an effective antiseptic, and especially a liquid soap, were shown to reduce the estimated number of bacteria on the skin progressively to as little as 1 percent of the initial count or even less.[5] It was concluded by Lowbury et al[2] that most of the disinfection occurs within the first two minutes and little further disinfection occurs after four minutes.[6]

Table 1. Comparison of Colony Counts with the Three Agents Using Both Brush Scrub and Hand Wash Technics Before Surgery

Agent	Colony Counts Before Gloving Brush Scrubs & Hand Wash		
	Low*	High†	Total
MD-7	25	58	83
Gamophen	25	41	66
pHisoHex	46	25	71
Total	96	124	220

*Low=50 colonies or less
†High=51 colonies or more

Table 2. Comparison of Colony Counts with the Three Agents Using Both Brush Scrub and Hand Wash Technics After Degloving

Agent	Colony Counts After Gloves Removed Brush Scrubs & Hand Wash		
	Low	High	Total
MD-7	16	67	83
Gamophen	40	26	66
pHisoHex	64	6	70
Total	120	99	219

Table 3. Comparison of the Colony Counts for Hand Wash and for Brush Scrub with Each of the Three Agents Used Before Gloving

Agent	Procedure	Colony Count Before Gloving		
		Low	High	Total
pHisoHex	Hand wash	22	5	27
	Brush scrub	24	20	44
	Total	46	25	71
Gamophen	Hand wash	14	21	35
	Brush scrub	11	20	31
	Total	25	41	66
MD-7	Hand wash	7	27	34
	Brush scrub	18	31	49
	Total	25	58	83
Grand Total		96	124	220

Table 4. Comparison of Colony Counts for Hand Wash and for Brush Scrub for Each of Three Agents Used After Degloving

Agent	Procedure	Colony Count After Degloving		
		Low	High	Total
pHisoHex	Hand wash	24	2	26
	Brush scrub	40	4	44
	Total	64	6	70
Gamophen	Hand wash	16	20	36
	Brush scrub	24	6	30
	Total	40	26	66
MD-7	Hand wash	8	26	34
	Brush scrub	8	41	49
	Total	16	67	83
Grand Total		120	99	219

Summary

A study was carried out to compare three hexachlorophene-containing agents for surgical

scrub and to compare the surgical brush scrub technic with these agents to the surgical handwash technic with the same agents. The materials used were pHisoHex, Gamophen leaves, and MD-7. The study revealed that pHisoHex was the most effective of the hexachlorophene preparations used and that, as far as disinfection is concerned, there is no significant difference between the surgical hand wash with pHisoHex and that of the surgical brush scrub.

Generic and Trade Names

3% Hexachlorophene suspension — pHisoHex (Winthrop Laboratories)

1% Hexachlorophene in powder — MD-7 (U.S. Borax Co.)*

6% Hexachlorophene in dry flake — Gamophen (Arbrook Co.)

*Manufacturer does not recommend this product for use in surgical scrub, but as an adjunct to hand cleansing throughout the rest of the hospital.

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Discussion of E.N.T. Case of the Month

(continued from p. 854)

The most likely diagnosis is juvenile angiofibroma, a histologically benign tumor seen in preadolescent boys. Since these tumors can be extremely vascular, routine office biopsy may result in profuse hemorrhage and should not be attempted. In most instances the characteristic clinical appearance dictates that tissue diagnosis should be obtained in the operating room under controlled conditions.

These tumors arise from the base of the skull in the area of the nasopharynx and they have the proclivity to extend into the various fissures and foramina that abound in this area. When dealing with a large tumor, the exact size and location should be determined by angiography (Fig. 2) prior to resection. This knowledge is extremely valuable in planning the surgical approach which must be tailored to each individual patient.



FIG. 2. Angiography is useful in outlining extent of these vascular tumors.

Gas in the Bladder — Cystitis Emphysematosa

Jan E. Bernie, M.D.; William E. Friedel, M.D., and Heinrich Schutte, M.D.

ALTHOUGH ONLY 118 cases of cystitis emphysematosa have been recorded[1] since its first description by Eisenlohr[2] in 1888, it is believed that the incidence of this disease entity is much higher. Diabetic neuropathy, with its obstructive qualities, and antibiotic-resistant infections in diabetes have increased, which may account for the increased incidence of cystitis emphysematosa. The disease is generally benign and transient, however, the striking radiographic and endoscopic findings impress the observer. Many questions remain unanswered in regard to the etiology and mechanism of the gas formation.

Mills,[3-6] who is generally given credit for bringing this condition into prominence in the American literature, defines cystitis emphysematosa as "an inflammatory condition of the bladder associated with the presence of gas vesicles in the tissues." Although the high incidence of diabetes and infection caused by gas-forming bacilli of the colon group has been recognized, it is interesting that Mills, in a series of autopsies felt that diabetes was not a conspicuous feature and that infection, not glycosuria, is an essential prerequisite. The exact chemical interaction between the tissue glucose and the gas-forming bacilli is still obscure, but obviously a fermentation of glucose to carbon dioxide, butyric, and lactic acid takes place.

In the nondiabetic cases, the production of gas is felt to be due to the breakdown of an abnormal albumen in the urine or to a strain of *Escherichia coli* capable of acting on a normal albumen. Burns,[7] who was able to culture a gas-producing bacillus resembling *Clostridium welchii,* suggested that this may be the etiologic agent in cases without diabetes mellitus.

Cystitis emphysematosa usually affects those in the age group between 40 and 80 years, but cases have also been reported in infants.[2,8,9] That the disease seems to occur twice as frequently in females as in males is felt to be due to the general overall increased incidence of cystitis in females.

Lund[10] was among the first to diagnose the disease at cystoscopy, describing the shining silvery vesicles, resembling air bubbles in their high reflectibility. His original description showed the spontaneous rupture of vesicles with the release of CO_2 into the bladder.

Bailey[11] in interpreting the familiar radiographic appearance of gas-filled vesicles (which cause the "cobblestone" effect, the ring of gas

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around the bladder in a "horseshoe" fashion, and of gas in the bladder lumen), emphasizes that the presence of gas in the bladder wall as well as in the lumen are manifestations of the same underlying cause, and that the term "pneumaturia" should be abandoned.

Case Report

A 56-year-old woman was admitted to the hospital with congestive heart failure. She was a known diabetic for about seven years. She had to be hospitalized two months previously because of coma, and she had been placed on treatment with insulin. During the treatment of her heart failure, *Klebsiella-Aerobacter* was found in the urine and, after therapy with kanamycin and Keflin had been without success, a urologic investigation was requested.

Laboratory data were as follows: hematocrit reading 43 percent; white blood cell count (WBC) 7,400 per cu mm; sodium 137 mEq/liter; chlorides serum 97 mEq/liter; carbon dioxide content, serum 26 mEq/liter; potassium serum 4.0 mEq/liter; fasting blood sugar 250 mg per 100 ml; blood urea nitrogen (BUN) 35 mg per 100 ml; and creatnine 2.8 mg per 100 ml. Urinalysis was negative for glucose and acetone, with acid reaction and full field WBC on microscopic examination. Urine culture yielded *Klebsiella-Aerobacter.*

Prior to any instrumentation, intravenous urograms showed air within the bladder on the kidney-ureter-bladder (KUB) film (Fig. 1.) The upper tracts were essentially within normal limits (Fig. 2). The lateral decubitus position film on the intravenous urogram showed an air fluid level within the bladder (Fig. 3). The cystogram showed mild (L) ureteral reflux. There was no evidence of enterovesical fistula (Fig. 4). Cystometogram demonstrated a hypotonic, flaccid bladder with poor proprioception and poor voiding pressures. Urethral calibration was carried out to 28F bougie-a-boule with no evidence of obstruction. Cystoscopy demonstrated patchy areas of hemorrhagic cystitis diffusely involving the bladder.

The patient was started on Foley catheter drainage and was given Furadantin with prompt clearing of her urine. and she was discharged for follow-up.

Summary

Cystitis emphysematosa is an inflammatory condition of the bladder associated with the presence of gas vesicle in the tissues. The presence of gas in the bladder wall as well as in the lumen



FIG. 1. Kidney-ureter-bladder film showing gas in bladder.

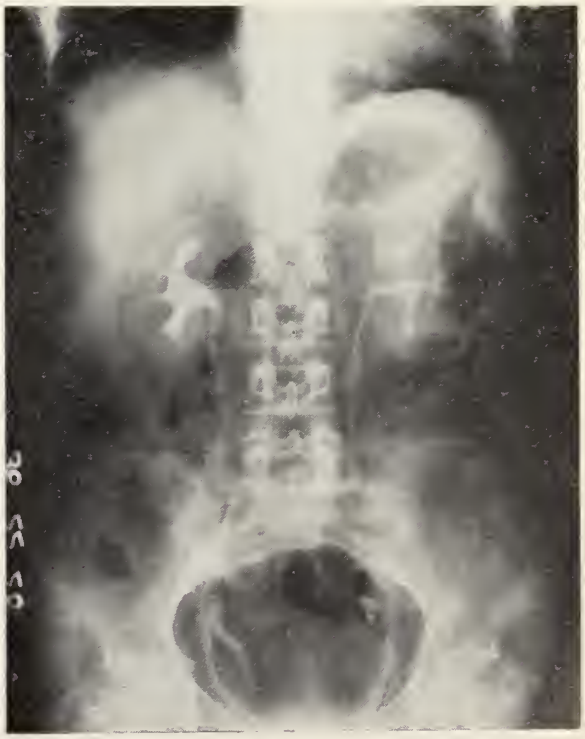


FIG. 2. Intravenous pyelogram demonstrating normal upper tracts.



FIG. 3. Lateral decubitus position film on intravenous pyelogram showing air fluid level within the bladder.



FIG. 4. Cystogram showing mild left ureteral reflux with no enterovesical fistula.

are manifestations of the disease producing the interesting radiologic findings. The disease usually occurs in diabetics with gas-forming bacilli acting upon tissue glucose to produce CO_2. Antibiotics and good drainage of the bladder effectively treated this patient.

Generic and Trade Names of Drugs

Sodium cephalothin—Keflin (Eli Lilly & Co.)
Nitrofurantoin—Furadantin (Eaton Laboratories)

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Gluteal Enterocutaneous Fistula Due to Regional Enteritis

Case Report

Wallop Manopiniwes, M.D., and Charles L. Cogbill, M.D.

REGIONAL ENTERITIS is a nonspecific, granulomatous, ulcerating, and cicatrizing disease which may involve any part of the gastrointestinal tract from stomach through colon. Clinically, there may be diarrhea, abdominal pain, fever, weight loss, and anemia. Although it was recognized at an earlier time, the first lucid and definitive description of the disease was given by Crohn, Ginzburg, and Oppenheimer[1] in 1932. Among its complications, fistulization, both internal and external is common, being reported in 14 percent[2] to 20 percent[3] of cases. An abscess appearing in the lateral gluteal region with ileocutaneous fistula formation following surgical drainage is so rarely reported that it appears worthwhile to describe in detail our case, recently treated in the Dayton Veterans Administration Hospital.

Case Report

A 22-year-old man was admitted to the hospital January 19, 1970 because of pain and swelling in the right hip region for the past six months. In July 1969, while in the army in the United States, he developed diarrhea alternating with constipation accompanied by mild, cramping, abdominal pain. He was hospitalized for two weeks and discharged with a diagnosis of colitis. He was treated with sulfonamides, steroids, and belladonna and at the time of discharge noted some improvement in his symptoms. During this hospitalization, he noted pain in the right hip joint without any antecedent injury to that area. In October 1969, pain in the right hip got worse and was associated with intermittent diarrhea. During the five months prior to admission, he sustained weight loss of about 15 pounds. At no time had the patient been outside the continental United States.

On *physical examination*, temperature was 38.2 C (100.6 F); pulse rate 104 beats per minute; respiratory rate 22 per minute; blood pressure 140/100 mm Hg; weight 92 pounds; and height 62 inches. The patient was thin and poorly nourished. He was alert, well-oriented, and cooperative. There was swelling and tenderness in the area just above the greater trochanter on the right. There was limitation of motion of the right hip joint due to pain.

The findings of the remainder of the physical

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examination including abdominal and rectal examination was not remarkable.

The hemoglobin level was 13 gm per 100 ml; hematocrit value 44 gm per 100 ml; white blood cell count (WBC) 23,500 per cu mm, with 89 percent neutrophils, 2 percent bands, 7 percent lymphocytes, 4 percent monocytes, and platelets adequate. Urinalysis was normal. Serology was nonreactive for syphilis. Prothrombin time was 49 percent, total protein 6.7 gm per 100 ml, albumin 2.9 gm per 100 ml, and globulin 3.8 gm per 100 ml. The serum bilirubin, thymol turbidity, alkaline phosphatase, transaminase, lactic dehydrogenase, cholesterol, calcium, phosphorus, and acid phosphatase all were normal. Cold agglutinins were 1:128, blood urea nitrogen (BUN) and sugar levels were normal, as were electrolytes except for serum potassium level of 5.9 mEq/liter. X-ray examinations of the chest, the right hip, and the pelvis all were normal. Intravenous pyelography showed dilatation of the right renal pelvis and barium enema was normal. Upper gastrointestinal series with small bowel follow-through showed narrowing of the terminal ileum (Fig. 1). Fistulogram performed by injection of radiopaque medium through the incision in the right hip region showed this material entering the terminal ileum (Fig. 2).

Soon after admission, incision and drainage of the abscess in the right hip region was performed. *Enterococci, Klebsiella, Staphylococcus aureus,* and *Pseudomonas* were cultured from the pus. Sigmoidoscopy revealed friable rectal mucosa that bled easily though the instrument could not be advanced more than 10 cm beyond the anal verge because of extreme discomfort to the patient. No ulcers or other lesions were seen. Laparotomy was performed, and a thickened, inflamed, distal ileum adherent to the cecum and ascending colon was found. This mass was firmly bound to the posterior abdominal wall just below and to the right of the sacral promontory. A fistulous tract was found originating in the distal ileum and extending posteriorly and inferiorly to the right of the sacrum. A right hemicolectomy was performed with resection of about 2 feet of distal ileum. Normal ileum was transected about 10 inches proximal to the diseased segment. The remainder of the intestine was grossly normal. After closure of the abdomen, the fistulous tract in the right gluteal region was opened widely and loosely packed with gauze. The patient made an uneventful recovery and at follow-up 14 months later weighed 99 pounds, was asymptomatic, and was working. The pathology report confirmed the clinical diagnosis of regional enteritis.

Comment

Fistulas associated with regional enteritis may be either internal or external. The incidence of internal fistula is hard to determine, but external fistulas were reported in 14 percent of Barber's cases[2] and 17.1 percent of the cases reported by Colcock and Vansant.[5] Colcock and Fortin[3] re-



Fig. 1. Small bowel study. "String sign" typical of regional enteritis is well shown.



Fig. 2. Fistula tract injection. Both tract and small bowel are demonstrated.

ported that 25 percent of their regional enteritis patients developed enterocutaneous fistula after appendectomy and it is generally believed that this complication often follows appendectomy in patients whose cecum is involved in the disease process. We have seen no report listing the incidence of spontaneously occurring enterocutaneous fistula but certainly it must be uncommon. In our case, one can speculate that the fistula from the ileum burrowed retroperitoneally, caudally, and posteriorly and escaped from the bony pelvis through the greater sciatic notch on the right side, appearing as an abscess in the posterolateral gluteal region. We were not able to pass catheters or probes completely through it from either direction but fistula-tract injection with radio-opaque material from the outside clearly demonstrated the connection of the fistula with the ileum. Surgical treatment—resection of the diseased bowel—was the same in this case as that generally advocated whenever operation is indicated in the management of regional enteritis.[2-6]

Summary

Fistula formation in regional enteritis is fairly common but spontaneous enterocutaneous fistulas are unusual. We have presented a case of spontaneously occurring enterocutaneous fistula which first presented in the lateral gluteal region. Treatment for this, as for other complications of regional enteritis requiring operation, is resection of the diseased bowel. This was done in our patient. He was in good health and was working when last seen in follow-up 14 months after operation.

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THE JUNE MEETING OF THE AMA in San Francisco was a very educational one. Everywhere one went, there was evidence that the AMA was meeting. While sightseeing in Sausalito, The Editor was handed a cleverly designed brochure obviously produced exclusively for doctors. Headed "Dear D-Doctor," it pictures the physician as a patient and presents the theme that man needs spiritual as well as physical healing. With a note, "We are some Jews who believe in Jesus and would like to share our faith with you," the reader is invited to write: Moishe Rosen, P. O. Box 545, Corte Madera, California 94925.

Hidradenitis Suppurativa and Pregnancy

Case Report and Discussion

George Woods, M.D.; Edward H. Vogel, M.D.; and James Croak, D.O.

HIDRADENITIS SUPPURATIVA is a chronic acneform infection of the cutaneous apocrine glands and subcutaneous tissue. The disease, as first described by Velpeau in 1839, is confined to the areas which contain apocrine glands, namely, the axilla, areola of the nipple, groin, perineum, circumanal, and periumbilical regions.

The clinical picture varies with the duration of the disease. It begins with subcutaneous induration, and as the induration advances, the skin becomes adherent, inflamed, and painful. Cellulitis surrounds the tumor with abscess formation, causing marked pain. Incision and drainage yields only a few drops of thick, viscous pus. The process may subside in several days, only to recur. In the chronic stage, the patient has numerous painful nodules surrounded by chronic inflammatory reaction. Tissue breakdown results in numerous interconnecting sinus tracts through which pus continuously drains from multiple openings in the skin.

The pathologic picture is that of pyogenic infection of the skin with involvement of the apocrine glands. Cultures of the pus yields a variety of saprophytic and pathogenic bacteria, the most common organisms being staphylococci and streptococci.

The disease occurs most often during the second and third decades of life, and its incidence is three times more frequent in women than in men. It is more common in Negroes than Caucasians because of the marked abundance of apocrine glands in these peoples. The disease is not infrequently associated with abnormalities of steroid metabolism such as Cushing's disease and endocrinopathies producing virilism in the female.

Although the exact etiology is unknown, common predisposing factors are thought to include: excessive axillary shaving, sweating with secondary maceration of skin, plucking of hairs, and application of deodorant and dipilatory creams. Shelly and Cohn have theorized that the tenacious fatty secretory products of the apocrine glands may inspissate in the tubules, producing obstruction and setting the stage for secondary infection and inflammatory reaction.[1] Cornbleet suggests that the apocrine glands are less active in the pregnant than in the nonpregnant state, and he reports two cases with improvement during pregnancy.[2]

This lesion is commonly mistaken for chronic burrowing ulcer, pyoderma, erysipelas, perirectal abscess, anal fistula, fungal infection, lymphopathia venereum, granuloma inguinale, tuberculosis cutis, and the skin changes often seen with ulcerative colitis.[3,4] The incidence of squamous cell carcinoma has been reported to be as high as 3.2 percent in the granulation tissue and sinus tracts of hidradenitis suppurativa.[5,6]

In Tennant's series, 23.8 percent of patients had anemia with hemoglobin levels below 10.0 gm per 100 ml.[7] The exact mechanism of the anemia, which does not improve with iron therapy, is unknown. The anemia is usually a microcytic, hypochromic type.

Treatment can be divided into three modalities: nonsurgical, x-ray, and surgical.

Nonsurgical therapy consists of antibiotic administration, warm compresses, and hygienic measures. Under this regimen the acute process will

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usually subside temporarily but will recur in long-standing cases.

X-ray has been very effective in treating axillary disease. When x-ray therapy is used, it is preceded by nonsurgical treatment until the acute process has subsided. After a dose of 450 to 500 rads, healing usually occurs within one month.[8]

Surgical procedures are varied and must be tailored to the individual case. Incision and drainage, combined with biopsy, may be employed when small areas are involved or as an initial attempt at cure. Excision with primary closure or split-thickness grafting should be employed for larger areas. Excision with rotation of full-thickness skin graft has been used with good results by Paletta.[9] In severe cases involving the vulva and mons, excision of all of the involved areas and skin grafting is necessary. Results of this extended type of excision have usually been good.

Several authors have stressed that the best results were obtained when the entire hair-bearing area was excised and covered with a split-thickness skin graft.[4,10]

Case Report

This 34-year-old Negro multipara was first found to have involvement of the vulva with hidradenitis suppurativa in July 1969. Four years prior to the vulvar involvement, she had hidradenitis suppurativa of both axillae, which was treated by surgical excision and split-thickness skin graft with good results. The remainder of her past medical history was not remarkable except for hemorrhoidectomy and fistulectomy some ten years ago. Of interest was the fact that the patient's stepdaughter also has axillary and perianal hidradenitis suppurativa.

The vulvar hidradenitis steadily became worse, although eight months after diagnosis, she became pregnant. The vulva at this time contained multiple draining abscesses. In addition, the labia majora pudendi and area of the mons contained areas of induration, inflammation, and was pock-marked with scars from previous abscess formation.

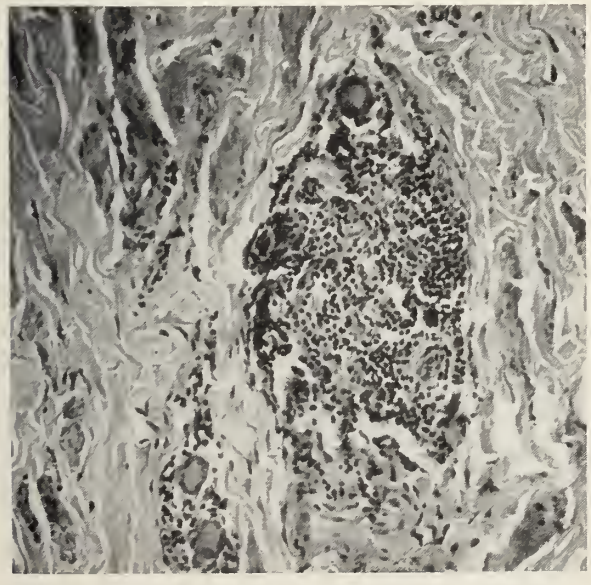


Fig. 1. Acute inflammatory cells surrounding and invading apocrine gland ducts.

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At 36 weeks, she was admitted to the hospital for evaluation of the status of the vulvar lesions and for some judgment about the obstetrical management for delivery. The labia majora pudendi were edematous, nodular to palpation, tender, and had scattered pustules over the surface. The labia minora pudendi and perianal skin were uninvolved. Considerable scarring was present over the entire vulva and the mons pubis. There was bilateral inguinal lymphadenopathy and no leg or ankle edema. Her hemoglobin level was 10.6 gm per 100 ml, in spite of iron therapy during her prenatal course. Cultures of the vagina showed no growth. Cultures of the vulvar pustules grew *Staphylococcus epidermidis* and alpha-streptococci, sensitive to cloxacillin.

She was treated with oral dicloxacillin, iodochlorhydroxyquin and hydrocortisone, Burow's solution sitz baths, and prednisone 40 mg. every other day for one week. There was little change in the course of the disease. Because of the extensive vulvar involvement with active infection and marked scarring, it was felt that elective cesarean section would be the best mode of delivery.

At 39 weeks, she was readmitted to the hospital for an elective cesarean section. A low cervical cesarean section was done through a midline abdominal wound. A 7 lb, 13 oz female was delivered with an Apgar score of 8. A bilateral Pomeroy tubal ligation was done at the time of cesarean section.

Cultures taken from the uterus at surgery revealed no growth. Two weeks after surgery there was no change in the hidradenitis suppurativa and her abdominal wound had healed by first intention.

Three months after delivery her vulvar lesions became worse. The induration, swelling, and pain were more marked. Abscess and pustule formation had markedly increased with several sinus tracts extending onto the inner thighs. The labia minora and perianal areas remained uninvolved. This acute exacerbation was treated with Burow's solution sitz baths, and iodochlorhydroxyquin with reasonable results. Surgical excision was decided upon as it seemed to be the only mode of therapy to offer substantial relief to the patient.

The area removed included an ovoid of tissue beginning anteriorly 3 cm above the clitoris extending laterally 1 to 2 cm onto inner thighs and included several sinus tracts. The incision was then continued posteriorly to encompass all of the affected tissue of the perineal body. Portions of the uninvolved labia minora were left as a sort of "pseudo" skin graft so that the wound could be closed without extensive skin grafting or tension. The skin edges were closed primarily without undue tension by using skin undermining and relaxing incisions.

Her postoperative recovery was uneventful and she was discharged ten days after surgery. The wound healed slowly, and the patient has gained marked relief from her symptoms.

Histologic examination of the surgical specimen showed interspersed areas of acute and chronic inflammation (Fig. 1), as well as areas where the apocrine

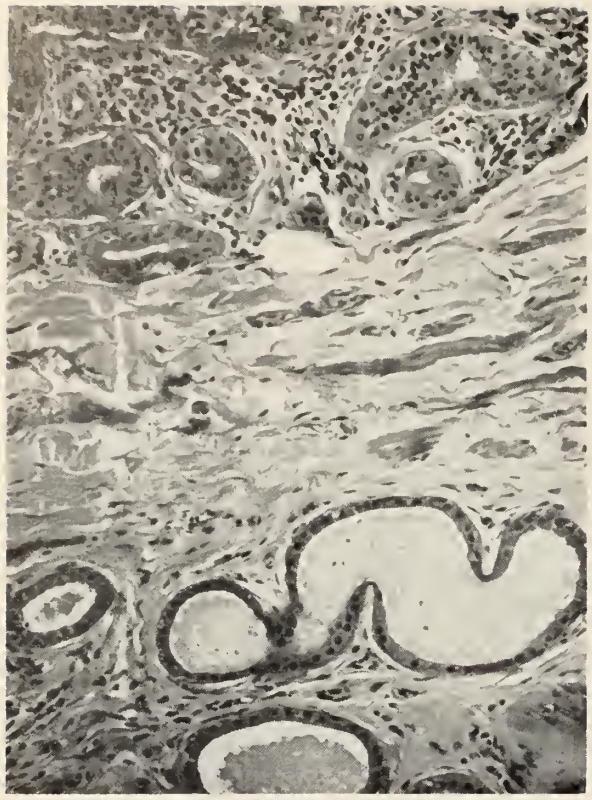


FIG. 2. Dilated apocrine glands with inspissated material and few acute inflammatory cells in lumen.

glands were uninvolved. Many glands were dilated and had inspissated material with an abundance of polymorphonuclear leukocytes in their lumens, establishing the diagnosis of hidradenitis suppurativa (Fig. 2). Microabscesses were scattered throughout the specimen, exhibiting total destruction of the glandular tissue. Surrounding these areas was evidence of chronic inflammation with plasma cells, lymphocytes, and deposition of collagen (Fig. 3). No evidence of carcinoma was found in any of the sections examined.

Comment

A case of hidradenitis suppurativa during pregnancy is presented. Except for the continuing vulvar problem and anemia, her prenatal course was uneventful. Because the perineum was markedly involved with small abscess and dense fibrous tissue from scarring, cesarean section rather than vaginal delivery was felt to be indicated. As the literature has suggested, the disease became worse following pregnancy. The authors feel that, with extensive involvement of the vulvar structures, aggressive medical treatment followed by surgical excision is warranted. The type of procedure done should be tailored to each patient's needs depending on the extent of the disease.

Summary

The case of hidradenitis suppurativa associated with pregnancy is presented. The literature is reviewed and the salient features of etiology, differential diagnosis, incidence of squamous cell carcinoma, anemia, and treatment of hidradenitis suppurativa are presented. Pregnant patients with severe hidradenitis suppurativa of the vulva should be delivered abdominally.

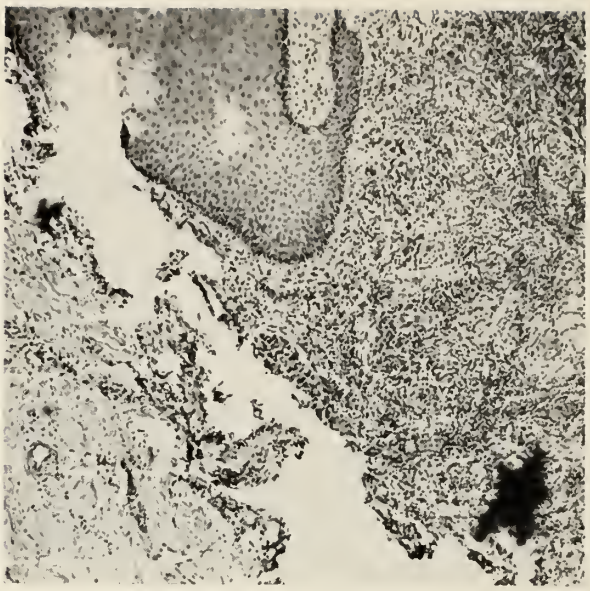


FIG. 3. Abscess formation with destruction of apocrine glands and with dense collagen in background.

Generic and Trade Names of Drugs

Sodium cloxacillin monohydrate—Tegopen (Bristol Laboratories)

Sodium dicloxacillin monohydrate — Veracillin (Ayerst Laboratories)

Iodochlorhydroxyquin and hydrocortisone—Vioform-Hydrocortisone (Ciba Pharmaceutical Co.)

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OB Emergencies

Anthony Ruppersberg, Jr., M.D.

THE PRIMARY PURPOSE of this column is to present material from time to time as a review and refresher program in obstetrics for those Ohio physicians, students, and paramedical personnel who attend maternity patients.

The material in this particular article will present data and statistics (1) from an exhibit prepared and displayed by the Committee during the Ohio State Medical Association Annual Meeting in Cincinnati and (2) from a Curbstone Consultation Seminar held by the Committee during the same meeting.[1]

The Exhibit

In 1971, the Chairman appointed a subcommittee to plan and prepare a scientific exhibit for display during the Annual Meeting of the Ohio State Medical Association in May 1972. The subcommittee consisted of Doctors Johnstone, Heilman, Glove, and Austin. The title of the exhibit (Fig. 1), located in booth number S-81, was "Fatal OB Emergencies." The display demonstrated data and statistics obtained by the Committee over a 15-year period from 1955 to 1969, inclusive. During this time, there were 3,212,003 live births reported in Ohio; the Committee discovered 1,047 maternal deaths during the same period of time. A graph in the center portion of the exhibit showed a yearly decline in the total number of annual maternal deaths, beginning with 99 in 1955 and ending with 45 in 1969. It also depicted the leading primary cause of death among 1,047 mothers as *hemorrhage,* with 273 deaths. Noted under "Other Causes" were 417 mothers who died from various remaining primary causes of death, 117 of which were due to pulmonary embolus. Eleven-point-six percent of these mothers died outside of Ohio hospitals. One hundred and six of these 1,047 deaths were listed as dead on arrival (DOA). Hemorrhage as a single cause of death also led with 34 cases; of these, 22 died of ectopic pregnancies diagnosed at autopsy. Again, under "Other Causes" of death of patients who were DOA, there were 42 cases, three of which were due to amniotic fluid pulmonary embolism and 21 due to pulmonary embolus, unclassified. On the opposite side wall of the exhibit, a small demonstration displayed some facts concerning sickle cell disease. Of the 1,047 maternal deaths recorded during the 15-year survey, four patients died of a sickle cell crisis; three were postpartum deaths; and one patient died undelivered. From the features available in each of these cases we find that anemia, weakness, icterus, fever, and abdominal pain with arthralgia were the commonest findings.[2]

Reprints concerning maternal deaths involving sickle cell anemia[2] were distributed at the booth, along with reprints of "Guiding Principles of Obstetric Care."[3] It might be added at this point that this exhibit won a Special Award for its presentation.

The author wishes to point out that this article is *not* to be considered as a *personal* accomplishment. Rather, it is published with a sense of pride focused upon members of the Committee, and the numerous other physicians throughout the

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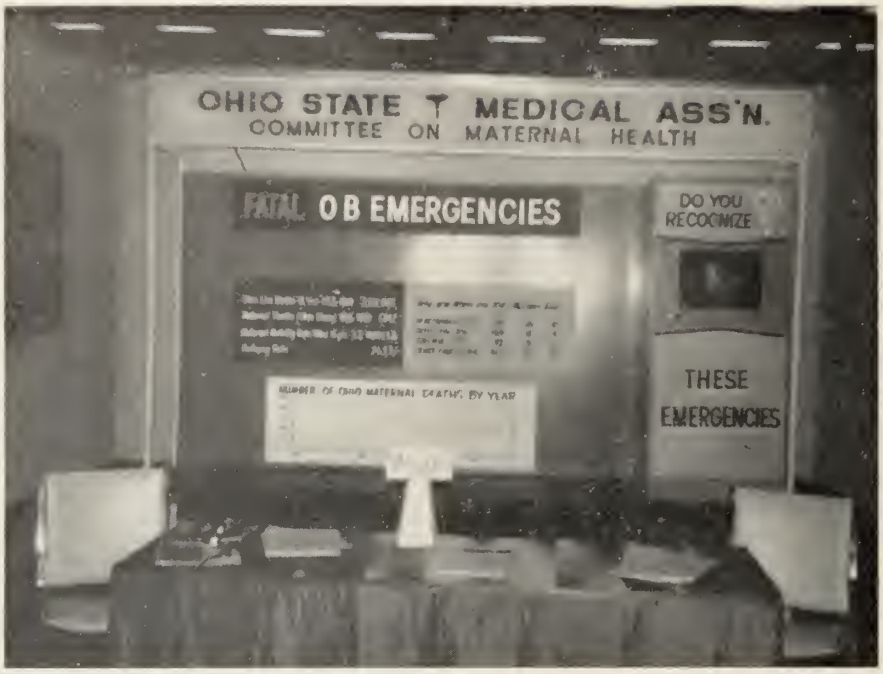


FIG. 1. "Fatal OB-Emergencies," Scientific Exhibit Booth S-81 by Committee on Maternal Health, OSMA Annual Meeting, May 9-12, 1972, Cincinnati, Ohio.

state who have contributed to the maternal health project sponsored by this Committee. Their participation and support are gratefully acknowledged.

The Seminar

At the request of the Council and the Program Committee for the convention, the Committee on Maternal Health sponsored an innovation known as a "1972 Curbstone Consultation Seminar." This was held May 10, 1972, during the OSMA Annual Meeting, and was titled "OB Emergencies." Committee members felt that an informal conference to provide educational material emanating from the Ohio Maternal Mortality Study would be well accepted.

The program was planned to informally present and discuss OB emergencies which occurred in the emergency room and, second, those which occurred usually *in* the hospital. To make the presentation more concrete, statistics from the emergency room of a 450-bed hospital located in the center of a metropolitan area were presented. These were statistics from 1968 through 1971 for the emergency room of Grant Hospital, Columbus, Ohio. The figures concerning total patients receiving emergency room care vs OB-GYN patients within that group are shown in Table 1. Approximately 5 percent of all the emergencies seen in this series constituted those having to do with the female patient.

The statistics from the emergency room of Grant Hospital were further examined, and it was found that the majority of the patients seen for obstetric or gynecologic complaints were seen for pelvic inflammatory disease (1,237 patients out of a total of 5,012). The next most frequently seen, were patients who presented symptoms and signs of abortion either threatened, inevitable, or incomplete (Table 2). Strangely enough, the next most frequently seen were 732 cases of uterine hemorrhage; the direct etiology in these cases could not be ascertained because of the variation in individuals attending the emergency room from time to time. However, patients with some type of pregnancy, not delivered, came to a total of 470 out of the 5,000.

This leads us to examine some of our methods of teaching diagnostic features to emergency room personnel assigned to caring for female patients in the emergency room.

Members of the Committee agree that some sort of an in-service educational program for emergency room personnel should be maintained. An excellent outline for such a program is contained in a small booklet by Mengert and Schneewind.[4] The symptoms and signs of obstetric emergencies constitute approximately five headings (Table 3). In these cases, it is essential to definitely establish a differential diagnosis so that therapy can be instituted promptly. This applies particularly to abortion vs ectopic pregnancy, false labor vs true labor, pelvic inflammatory disease (PID) vs appendicitis, ovarian cyst vs ascites, and eclampsia vs epilepsy (Table 4).

The authors of this excellent booklet have properly outlined the *do's* and *don'ts* connected with obstetric emergencies (Table 5). There are

four of each of these which, if followed meticulously, will enable the emergency room physician to avoid a trap concerning complex diagnoses.

Inpatients

The obstetric emergencies occurring in patients who have been hospitalized are too numerous to discuss in detail. In the Ohio Maternal Mortality Study, *hemorrhage* as a primary cause of death has been the outstanding leader with questionable eminence. The Committee has reported on this many times, beginning with a ten-year survey.[5] In the ten-year survey, the Committee reported 206 maternal deaths due to hemorrhage with 63 cases of ruptured uterus and 40 of ectopic pregnancy. This proportion seems to be substantiated in subsequent reports by the Committee.[6,7]

Ruptured Uterus

The diagnosis of ruptured uterus[6] has been discussed by the Committee on numerous occasions. "Guiding Principles for Obstetric Care"[3] outlines some of the preventable measures to be utilized by the physician, especially *immediate* exploration of the postpartum uterus and genital tract. The treatment is usually surgical with an interim utilization of intravenous fluids and blood, or blood substitutes, if indicated.

Table 1. Total Patients, and OB-GYN Patients Per Year (4 Years), Emergency Room Service, Grant Hospital, Columbus, Ohio

Year	Total Patients	OB-GYN Patients
1968	24,533	1,140
1969	23,117	1,300
1970	25,077	1,206
1971	27,375	1,366
Total (4 years)	100,102	5,012

Table 2. Prevalent OB-GYN Problems (4 Years), Emergency Room Service, Grant Hospital, Columbus, Ohio

Abortion	825
Ectopic pregnancy	84
Hemorrhage, uterine	732
Inflam. disease, pelvic	1,237
"Leukorrhea" (vaginitis)	163
Rape	267
"VD"	235
Pregnancy, NOT delivered	470
Dysmenorrhea	157
All others	842
Total	5,012

Table 3. Symptoms and Signs in Obstetric Emergencies

Vaginal bleeding
Vulvar mass
Abdominal pain
Abdominal mass
Convulsions

Table 4. Differential Diagnosis in Obstetric Emergencies

1. Abortion vs ectopic vs PID.
2. False labor vs true labor
3. PID vs appendicitis
4. Ovarian cyst vs ascites vs fibroid tumor
5. Eclampsia vs epilepsy

Table 5. Do's and Don'ts in Obstetric Emergencies

Do's
Speculum examination
Remove tissue from Cx Os
Prepare transfusion . . . IV fluid
Remember preg! ectopic! (Culdocentesis)
Don'ts
Omit exam. of breast & abdomen
Exam. possible PREVIA or ABRUPTIO
Plunge trocar into abd. w/ascites
Dismiss PID w/o revisit next day

Ectopic Pregnancies

Forty of the 206 deaths due to hemorrhage[5] were due to ectopic pregnancy. There is no substitute for a complete and carefully taken history and physical examination of every female patient. One measure, which the Committee supports completely, is the use of culdocentesis. Members have pointed out in the past that, in an emergency, this can be done without anesthesia in a crisis; when the operator obtains blood, the diagnosis is apparent.

Infection

The second single contributory cause of maternal death is infection. In the exhibit (Fig. 1), the Committee noted that there were 206 maternal deaths from infection among the 1,047 who died in the 15-year period. A great majority of these infections were secondary to an attempted or a completed criminal abortion, puerperal sepsis following long-ruptured membranes, or to contamination during a surgical procedure. The most important criterion is for the physician to anticipate the causitive organism and commence antibiotic therapy at once. The Committee advocates immediate cultures of the cervix, the blood, and the urine, and/or a wound infection (if present); within 48 to 52 hours, the organism and its sensitivity causing the pathologic process can be isolated and treated specifically. Meanwhile the physician must balance the electrolytes, taking due caution not to overload the circulatory system with an

excess of fluids. Septic shock must be anticipated at all times, as outlined in "Guiding Principles."[3]

Toxemia

Gradually, toxemia is diminishing each year as a cause of maternal death in the State of Ohio. However, there were 103 patient deaths from toxemia in the 1,047 reported in the exhibit. The great majority of these developed *eclampsia*. From time to time, the Committee has pointed out the importance of adequate prenatal care as a measure to prevent toxemias.[3]

Other Causes

Last but not least, there remains a miscellaneous group of other causes of maternal death, as classified by the Committee on Maternal Health. In order of prevalence, these usually are pulmonary embolus, cardiac disease, and amniotic fluid embolus. The prevention of embolic phenomenon is difficult, sometimes futile. If the physician anticipates the possibility of their occurrence, he may be able occasionally to prevent such a patient from maternal death; patients who have had varicosities, thrombophlebitis, or a febrile puerperium should be suspected candidates. However, in the experiences of the Committee, with the cardiac-disease patient identified early as a *high risk patient* and receiving adequate, intensive prenatal care, usually the outcome is satisfactory for both mother and infant. These facets are covered completely in "Guiding Principles."[3]

We reiterate, the *high risk* OB patient usually can be saved from fatality if she is identified early. The last annual Maternal Mortality Report for Ohio for the year 1969 prepared and submitted by the Committee,[7] revealed that of 44 maternal deaths reported, 27 of the patients were classified as "high risk OB" patients before pregnancy. About one fourth of these (five) had factors related to the primary cause of death! All of these factors came under the "Other Causes" classification. Obviously, this behooves the practicing physician to identify the *high risk* patient at an early date and to then provide intensive care for her during her pregnancy, labor, and delivery.

Under the remaining "Other Causes" of maternal death, the Committee discovered four maternal deaths due to sickle cell anemia.[2] The patient who has hemaglobinopathy should be discovered early, studied thoroughly, and if she is found to be a crisis candidate, her pregnancy is not justified. For the past two years, the Committee has been developing "Ready Reference OB Records" as a project. Each sheet contains a *very brief* check-list summary of *important* points, in the diagnosis and immediate management of ONE condition which is potentially a "Fatal OB Emergency." Free copies will be available at the booth of the Committee's 1973 Scientific Exhibition.

Conclusions

1. A resumé of obstetric emergencies is presented, based upon data gleaned from the Ohio Maternal Mortality Study.

2. The experiences derived by the Committee on Maternal Health are reflected in an award-winning exhibit, and a Curbstone Consultation Seminar.

3. Specific areas in the diagnosis and management of the more common obstetric emergencies are related briefly.

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Professional Activities



Proceedings of The Council

Meeting of July 28-30, 1972

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Friday, Saturday and Sunday, July 28, 29, 30, 1972. The meeting on Friday, July 28, was held at the Sheraton-Columbus Motor Hotel and the meetings on Saturday and Sunday were held at the Headquarters Office, 17 South High Street, Columbus. Those present were the following:

Officers and Councilors — All members of the Council except Dr. Oscar W. Clarke, Gallipolis, President-elect.

County Medical Society Executive Secretaries and Representatives — Mr. Waldo Smith, Lima; Mr. E. Clifford Roberts and Detective Ruppert, Hamilton; Mrs. Marion L. Wilcoxson, Springfield; Messrs. Robert A. Lang and Donald W. Mortimer, Cleveland; Mrs. Barbara Wolfert, Sandusky; Miss Jean Armour, Columbus; Messrs. Edward F. Willenborg and Edward W. Hoffmann, Cincinnati; Messrs. R. W. Elwell and Lee F. Wealton, Toledo; Messrs. Earl Shelton and Richard G. Tapia, Dayton; Mrs. Pat Askins, Fremont; Mr. S. H. Mountcastle, Akron; Mrs. Kay Ticknor, Warren.

Guests — Mr. James E. Pohlman, Columbus, OSMA legal counsel; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Mr. James S. Imboden, Columbus, AMA Department of Field Service; Mr. David B. Weihaupt, Chicago, Director, Department of Membership and Planning of the American Medical Association; Mr. Bernard D. King, Columbus, representative of the Student A.M.A.; Mr. William J. Lee and Captain Ed Valentine, representing the State Medical Board; Dr. John W. Cashman, Columbus, Director, Ohio Department of Health; Dr. Paul S. Metzger, Columbus, Vice-President and Health and Medical Director of the Nationwide Insurance Company; and Dr. Kenneth Paul Turner, Logan.

Members of the OSMA Staff — Messrs. Hart F. Page, Charles W. Edgar, Herbert E. Gillen, Jerry J. Campbell, David Rader, Mrs. Katherine Wisse, Mr. R. Gordon Moore and Mrs. Gail Dodson.

Minutes Approved

Minutes of the meetings of the Council held April 15-16 and May 11, 1972 were approved by official action.

Reports of Councilors

The Councilors reported on activities in their respective districts.

Ear Piercing

The Council received a communication from Dr. John W. Cashman, Ohio Director of Health, dated July 13, 1972, regarding the hazards to the public of ear piercing as carried out in department stores in various cities of Ohio. Mr. Lee reported that the Ohio State Medical Board also has this matter under consideration.

The Council requested the Department of Public Relations to investigate the feasibility of

issuing, with the Ohio Director of Health, a joint news release concerning this matter.

Coalition for Quality Health Care

Mr. Page explained the organization and history of the Ohio Coalition for Quality Health Care, indicating that the members constitute the Ohio State Medical Association, Ohio Hospital Association, Ohio Osteopathic Association of Physicians and Surgeons, Ohio Association of Osteopathic Hospitals, Ohio State Pharmaceutical Association, Ohio State Dental Association, Ohio Optometric Association and the Ohio State Council of Retail Merchants. Officers of the coalition are: Mr. James Newcomer, Ohio Hospital Association, co-chairman; Mr. Hart F. Page, co-chairman, and Mr. David Rader, secretary, Ohio State Medical Association.

It is anticipated that the coalition will work as a unit whenever possible for the improvement of the Medicaid program and to furnish information for legislative hearings on welfare problems.

The Council voted to approve the principle of the coalition and the participation of the Ohio State Medical Association and its staff.

Medicare Report

Dr. Paul S. Metzger, Vice-President and Health and Medical Director, Nationwide Insurance Company, discussed the Medicare Program with the Council and guests. He announced that Mr. Robert Ourant has become Vice-President of the Nationwide Insurance Company in charge of the Medicare program.

He announced that many of the mechanical problems that had crept into the program were being identified and corrected.

Some of the statistics for fiscal year 1972 were presented. He stated that 2.4 million claims had been received and that 2.4 million claims had been processed and that there was a current pending load of 151,000 which represented the lowest pending in the last 12 months. The statistics further showed that 45 percent of this 151,000 were over 30 days old, and there were a few comments submitted reflecting that these were due to inadequate material and inadequate data to properly handle.

The current assignment rate was discussed, which in Ohio is running at 31 percent.

He progressed to a discussion of the reimbursement bases for fiscal year 1973, and it was pointed out that the reasonable charge as defined by Social Security would be based on charge date accumulated in 1971 with the prevailing at the 75th percentile but there would be no increase more than the 2.5 percent allowed by the wage-price freeze. Tentative target dates of implementation of this change of profile base were listed as medical-surgical change to August 15, 1972 and radiology, pathology, and anesthesiology on September 8, 1972.

Practicing Law Institute

The Council approved the publicizing of the meeting of the Practicing Law Institute in Cleveland, Ohio, August 14, 15, 1972, to consider the subject "Medical and Dental Malpractice."

Member Appeal

A letter from a member, requesting the assistance of the Association in regaining a position in state government, was discussed by the Council. It was the opinion of the Council that, inasmuch as this matter is under consideration by the courts, it would be inappropriate for the Council to act at this time.

Annual Meeting

Mrs. Gail Dodson, convention coordinator, reported on the 1972 Annual Meeting and on plans for the 1973 session. Mrs. Dodson announced the attendance at the 1972 meeting was 3,029, which was an increase of 72 over the 1971 attendance of 2,957. Member participation was increased from 1,049 in 1971 to 1,118 in 1972.

Resolutions in 1972 House of Delegates

The Council thereupon took up those resolutions from the 1972 House of Delegates which were passed and which require implementation. The number of each resolution, a brief summary, and the Council action are as follows:

Am. Resolution No. 5-72, Report on Implementation of Resolutions Passed by the House of Delegates of the Ohio State Medical Association — Referred to the OSMA Executive Director for implementation.

Resolution No. 6-72, Recognition for the Association of County Medical Executives, Inc. — Referred to ACME.

Resolution No. 7-72, Change in Ohio State Medical Association Bylaws — This change has been included in the newly published revisions of the OSMA Constitution and Bylaws.

Am. Resolution No. 9-72, Proposed Solution to Current Malpractice Problems — Referred to the Committee on Insurance and the OSMA-Ohio State Bar Association Liaison Committee.

Am. Resolution No. 10-72, Attorneys' Contingency Fees in Relation to Current Malpractice Problems — Referred directly to the Ohio State

Medical Association-Ohio State Bar Association Liaison Committee.

Resolution No. 12-72, Funding of Comprehensive Health Plans — Referred to the Committee on Government Medical Care Programs.

Resolution No. 13-72, Medicare Part B — Referred to the Committee on Government Medical Care Programs.

Am. Resolution No. 14-72, Policy Statement on Alcoholism — Was introduced at the June AMA meeting (A-72) and was incorporated with another resolution on the subject of alcoholism and was amended and passed.

Sub. Resolution No. 16-72, Requests OSMA to establish Peer Review Organization — The Ohio State Medical Association has complied with this request.

Sub. Resolution No. 17-72, Closed Panel or Prepaid Group Practice — Referred to the Ohio State Medical Association-Ohio Medical Indemnity, Inc. Liaison Committee.

Am. Resolution No. 18-72, Commending the Council of the Ohio State Medical Association — Referred to the OSMA Council for its information.

Sub. Resolution No. 21-72, Review of Ohio Medical Indemnity, Inc., Coverages — Referred to the Ohio State Medical Association-Ohio Medical Indemnity, Inc., Liaison Committee.

Sub. Resolution No. 22-72, Annual Chest X-ray Examinations — Referred to the Ohio State Medical Association staff for implementation.

Sub. Resolution No. 23-72, Ohio Department of Public Welfare Forms — Referred to the Committee on Government Medical Care Programs and the Medical Advances Institute.

Am. Resolution No. 24-72, Exposure of Failure of Government Medical Programs — (1) Referred to the Department of Public Relations and the Committee on Government Medical Care Programs. (2) Was introduced at the June meeting of the AMA (A-72) and referred to the AMA Board of Trustees.

Am. Resolution No. 25-72, Proposed Amendment to the Bylaws of the Ohio State Medical Association — Has been included in the newly published revisions of the Constitution and Bylaws.

Sub. Resolution No. 26-72, Medical Advances Institute — Referred to Medical Advances Institute.

Sub. Resolution No. 34-72, Health Care — A Negotiable Service — Referred to the Committee on Government Medical Care Programs.

Resolution No. 36-72, Average Length of Stay — Referred to the Committee on Insurance.

Resolution No. 39-72, Unit Rule — Approved principle opposing Unit Rule and rejected resolution. House is therefore on record as disapproving Unit Rule.

Am. Resolution No. 40-72, Phase II — Was introduced at the June meeting of the American Medical Association (A-72) but was withdrawn because the resolution was inaccurate.

Resolution No. 44-72, Regional Medical Programs — Referred to the Committee on Government Medical Programs.

Resolution No. 46-72, Dissolution of the American Board of Nuclear Medicine — Was introduced at the June meeting of the American Medical Association (A-72) and part of the final AMA action was as follows: "The American Board of Nuclear Medicine, a conjoint board, can issue a general certificate in the field of practice represented by the conjoint board, and its sponsoring primary boards may issue special certificates in the related limited fields of their particular interest . . ."

Am. Resolution No. 47-72, Homicide by Handguns — Ohio Legislature, adopted H.B. 143, effective September 5, 1972. Resolution introduced at the June meeting of the American Medical Association (A-72). A substitute resolution was adopted in lieu of the Ohio resolution.

Am. Resolution No. 49-72, H.R. 1 — Referred to the Committee on Insurance and the Committee on Government Medical Care Programs.

Am. Resolution No. 51-72, Non-Therapeutic Use of Pharmacological Agents by Athletes — Was introduced at the June meeting of the American Medical Association (A-72) and was amended and adopted.

Resolution No 52-72, Phenylketonuria — Referred to the Committee on Laboratory Medicine.

Am. Resolution No. 55-72, Hospital Board — Referred to the Committee on Hospital Relations.

Am. Resolution No. 56-72, Relative Value Fee Schedule — Referred to the Committee on Government Medical Care Programs and the Committee on Insurance.

Resolution No. 60-72, Critical Need to Reevaluate Available Resources to Support Hospital-Based Training Research and Educational Programs — Referred to the Committee on Hospital Relations. Was introduced at the June meeting of the American Medical Association (A-72) and was referred to the AMA Board of Trustees.

Sub. Resolution No. 62-72, Ohio Medical Indemnity "Hold Harmless" — Referred to the OSMA-OMI Liaison Committee.

(Continued on Next Page)

Sub. Emergency Resolution No. 65-72, Special AMA Open Hearings — Resolution was forwarded to the American Medical Association as directed.

Resolution No. 66, Model Medical Care Foundation (Report of Ad Hoc Committee on Health Care Delivery) — Referred to the Ad Hoc Committee for Study of Health Care Delivery Systems.

Report of the OSMA Commission on Medical Education (Re: Resolution No. 3-71, Continuing Education as a Requirement for Membership in the OSMA) — Referred to the Commission on Medical Education.

American Medical Association

Mr. Gillen reported to the Council on the June meeting of the American Medical Association in San Francisco and issued a written report covering the disposition of resolutions introduced by the Ohio delegation.

The Council noted that Dr. John Budd will be a candidate for reelection to the Board of Trustees of the American Medical Association in June, 1973, and voted unanimously to nominate Dr. Budd to succeed himself on that Board.

Ohio Director of Health

Dr. John W. Cashman, Ohio Director of Health, addressed The Council concerning problems under consideration by his department of interest to the Ohio State Medical Association and to the physicians of Ohio. He announced that the department would take an interest in the financing aspects of Medicare and Medicaid and announced the appointment of Mr. Edward A. Lentz to the position of deputy director for medical care administration.

Dr. Cashman discussed emergency medical care and expressed his hope for a coordinated statewide effort to improve emergency health services. He pointed out that the executive administration of Ohio is interested in the viability of local government, reorganization of the state government and the redistricting in some cases of state services. He indicated this could possibly include the redistricting of local health departments. Dr. Cashman advised the Council that he would be glad to discuss problems with the county medical societies if requested to do so.

Constitutions and Bylaws of County Societies

Licking County

The revised Constitution and Bylaws of the Licking County Medical Society **were approved** by the Council, contingent upon the adoption of one amendment.

Portage County

Revisions in the Portage County Medical Society Constitution and Bylaws received **final approval.**

Membership

Statistics

Mrs. Wisse reported on membership statistics. As of July 26, 1972, she indicated that the Seventh, Eighth and Eleventh Councilor Districts showed gains in membership for State Association members and that the Eighth District showed gains for American Medical Association members.

The Councilors requested lists of delinquent members for their personal attention.

The report was accepted.

Active Membership for Interns and Residents

The Council considered a letter from the American Medical Association, expressing the hope that the Ohio State Medical Association will make an active membership category available for interns and residents.

The Council instructed the legal counsel to study possible changes necessary in the OSMA Bylaws to accomplish this objective and to report at the next meeting of the Council.

Membership Records Systems

Mrs. Wisse filed a written report of her analysis of various computerized membership record systems.

The Council authorized continued investigation of a computerized membership record system to determine what might be available locally, possibly through Ohio Medical Indemnity, Inc., and costs involved to implement the best system for OSMA requirements.

Report of David B. Weihaupt

Mr. David B. Weihaupt, Director of the Department of Membership and Planning of the American Medical Association, addressed the Council with regard to the organization and the operation of his department and its hopes for future plans. He asked the cooperation of the Ohio State Medical Association and Ohio's county medical societies in the work of his department.

Auditing and Appropriations Committee

The minutes of the July 28, 1972 meeting of the Auditing and Appropriations Committee were presented by Mrs. Wisse. Included in the report of the committee was the following reference to the OSMA building program:

Dr. Henry reported on his findings regarding the Market-Mohawk area which would cost $52.50



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per square foot for a new building constructed in this area.

He presented the drawings and plot plan of a suggested office building designed by Kevin Flaherty and suggested a building 62.8 feet by 98.8 feet, resulting in about 10,000 square feet on the first and second floors and 40 parking spaces on the site.

The Auditing and Appropriations Committee recommended that the Council proceed with the acquisition of property located at Willow and High Streets, at a cost of $180,000 and to proceed with the suggested building not to be less than 12,500 square feet at a cost of $350,000 or a basic cost of $530,000.

The Council authorized the appointment of a building committee. The President appointed the following to this committee: James L. Henry, M.D., chairman; William R. Schultz, M.D., David Fishman, M.D., Maurice F. Lieber, M.D., and Mr. Hart F. Page.

On **motion** by Dr. Fishman, seconded by Dr. McLarnan and **carried,** the Council voted to accept the recommendation of the committee but directed that the Building Committee not be bound by an exact dollar cost. The Council instructed the committee to proceed with plans and development of the project to the point where the Council will consider the approval of the necessary funds to accomplish the objectives.

The Council authorized the Pension Committee to meet with the legal counsel, trust officers and accountants on plans for financing the project.

The report of the Auditing and Appropriations Committee as a whole, as amended, **was adopted,** with action on one item deferred until the next meeting of the Council.

By official action, the Council adopted the following resolution:

RESOLVED, That this corporation purchase parcel number 15982, being the property located at Willow Alley and South High Streets in Columbus, Ohio, for the purpose of erecting a new headquarters building.

RESOLVED FURTHER, That James L. Henry, M.D., Secretary-Treasurer of this corporation and chairman of the building committee, is hereby authorized to enter into an agreement on behalf of this corporation with the owners of the property located at Willow and South High Streets in Columbus, Ohio, to purchase such property for the sum of One Hundred and Eighty Thousand Dollars ($180,000.00).

RESOLVED FURTHER, That James L. Henry, M.D., is hereby authorized to execute all instruments and make all payments necessary to carry the foregoing resolution into effect, and to accept all documents, duly executed, which may be necessary for the transfer and conveyance of the land to this corporation.

Committee Reports

Joint Advisory Committee on Sports Medicine

The minutes of a meeting of the Joint Advisory Committee on Sports Medicine on April 19, 1972, were presented by Mr. Gillen in the absence of Mr. Clinger.

The Council requested that the physical examination form submitted by the committee be revised and simplified before it is adopted. The Council discussed the need for a standard physical examination form for college entrance requirements.

The report as a whole was accepted for information.

Ohio Cancer Coordinating Committee, Inc.

Minutes of a meeting of the Ohio Cancer Coordinating Committee, Inc., on May 3, 1972, were presented by Mr. Gillen in the absence of Mr. Clinger. The report was accepted for information.

Commission on Medical Education

The minutes of the May 24, 1972, meeting of the Commission on Medical Education were presented by Mr. Edgar.

Commission Reorganization

In connection with the report, the Council delegated to the President of the Ohio State Medical Association the authority, in consultation with the chairman of the Commission, to reorganize the Commission.

Physician Assistants

A proposal to draft legislation on physician assistants was deferred for the present.

In response to a request of the Medical Board for a conference on physician assistants, the Council delegated to the President, President-elect, Past-President and Secretary-Treasurer the authority to meet with the members of the Ohio State Medical Board to discuss the matter.

Philip R. Lee Report

The Council received a copy of the Ohio Board of Regents Study of Area Health Education Centers prepared by Philip R. Lee, M.D., Chancellor of the University of California Medical

Center, San Francisco, who served as a consultant to the Board. The report is dated June 30, 1972.

Committee on Nursing

The minutes of a meeting of the Committee on Nursing held on May 31, 1972, were presented by Mr. Rader and **were approved.**

Joint Meeting

The minutes of a joint meeting of the OSMA Committee on Nursing, the Ohio Nurses Association, Ohio Osteopathic Association of Physicians and Surgeons and the Ohio State Pharmaceutical Association on May 31, 1972, were presented by Mr. Rader and were accepted for information.

Family Practice Scholarship Subcommittee of Committee on Rural Health

The minutes of a meeting of the Family Practice Scholarship Subcommittee on June 14, 1972, were presented by Mr. Gillen in the absence of Mr. Clinger and were accepted for information.

Committee on Maternal Health

Minutes of a meeting of the Committee on Maternal Health on June 25, 1972, were presented by Mr. Gillen and were accepted for information.

Committee on Eye Care

Minutes of a meeting of the Committee on Eye Care on June 28, 1972, were presented by Mr. Rader.

The Council **approved** the recommendation of the committee that all ophthalmologists use only the physician invoice forms when billing the Ohio Department of Public Welfare for professional services.

The Council **approved** the committee's recommendation that forms used for a reimbursement of costs for dispensing spectacles be called "optical service" forms.

Welfare Invoice Forms Unacceptable

The Council **approved** the recommendation of the committee that the physician invoice forms proposed by the Ohio Department of Public Welfare, as presented before the committee, be rejected by the Ohio State Medical Association on the basis that they are not practical, that they exceed the levels of information needed, and that they are an unnecessary infringement upon the time of both the physician and his office staff.

In this connection, the Council voted to notify the Ohio Department of Public Welfare that the form is unacceptable and to make a formal entreaty that it not be put into use by the department.

The Council voted to instruct the legal counsel to investigate and advise Council regarding the possibility of an injunction to support the Ohio State Medical Association's request that this form not be utilized.

The Council **approved** a further recommendation of the Eye Care Committee that the Ohio Department of Public Welfare be requested to consult with the appropriate specialty of medicine whenever the department is making a decision which will affect that specialty and that such consultation be implemented through the Medical Advisory Committee to the Ohio Department of Public Welfare, which includes the various specialties among its members.

The report as a whole was accepted as amended.

Committee on Insurance

The minutes of a meeting of the Committee on Insurance on July 19, 1972, were presented by Mr. Campbell.

Claim Forms

Adopting in part a recommendation of the committee, the Council voted its reaffirmation of its **approval** of the two insurance claim forms previously recommended by the Ohio State Medical Association and pointed out that these are the only forms approved by the Association.

Aetna Life and Casualty Company

The Council **approved** the text of the following communication to be directed to Mr. Lawrence M. Cathles, Jr., Senior Vice-President of the Aetna Life and Casualty Company, Hartford, Connecticut, in reply to his letter to the Ohio State Medical Association dated June 9, 1972:

Dear Sir:

The Ohio State Medical Association has studied the situation described in your letter of June 9, 1972.

It must be recognized that the individual physician has the unassailable privilege of establishing his fee for service. This is nonnegotiable.

When an insurance company, or any other third party, engages in a contract with a person or group of persons to be responsible for payment of moneys to defray expenses for professional medical services, the physicians of Ohio are not necessarily obligated to be a party to such contract. When the patient presents himself to the physician to request professional services, and the physician agrees to provide such services, and does provide such services, the third party insurer does not become a party to that contract between physician and patient.

The insurance company, or any third party, does not consult the physician in forming a

contract of its insured. The physician does not consult the insurance company, or any third party, in engaging in a contract with the patient.

In order that Aetna eliminate any antagonisms between Aetna and physicians caused by the administration of contracts, the Ohio State Medical Association recommends that:

1. Aetna accept Ohio's usual, customary and reasonable fee concept, and base its contractual, actuarial and payment projections on that recognition.

2. Aetna utilize OSMA's long-standing review mechanisms whereby any conflicts, not just fee questions, could be reviewed at the local level whenever possible, at the state level when local review is not possible.

Physicians of Ohio and their county medical societies have been advised frequently by the Ohio State Medical Association of the individual physician's responsibilities in determining his fee for service. Further, in cases where the physician determines that the patient's care and treatment require more than usual time, skill and attention, the physician's fee will represent such requirement, and the patient is so advised.

The Ohio State Medical Association peer review program has operated most successfully for many years to the benefit of the patient, the physician, and to the benefit of Workmen's Compensation, Medicare, Medicaid, and the private and voluntary health insurance industry.

We see no reason why this successful system could not function in Aetna's case, and we welcome your participation and cooperation.

Sincerely,

William R. Schultz, M.D.
President

The Council expressed the opinion that it is unnecessary to send copies of these two letters to every member of the Ohio State Medical Association.

Professional Liability Legislation

The Council **adopted** the committee's recommendation that Senate Bill 242 of the 109th General Assembly be introduced again in the 110th. Such proposal was sponsored by the Ohio State Medical Association to legislate forms to be used in obtaining the patient's "informed consent." The Council also suggested that the OSMA broaden the base of support for this legislation.

With regard to the committee's suggestion for legislation to make mandatory the report by insurance companies of claims experienced with regard to malpractice insurance, the Council instructed the legal counsel to informally discuss the matter with major underwriters of professional liability insurance companies concerning their attitude prior to proceeding with such legislation.

Mental Health Benefits

The Council accepted the committee's recommendation that Dr. Manuel E. Gordillo, Lakewood, and the Ohio Psychiatric Association present a specific legislative proposal to the Insurance Committee of the Ohio State Medical Association with regard to comprehensive insurance coverage for mental illness. The Council specified that such legislation and discussion be limited to acute mental illness.

OSMA Major Medical Insurance

The Insurance Committee informed the Council of a request from the Daniels-Head Agency for an increase in premiums for the OSMA sponsored major medical insurance program. The Council noted the request for a rate increase and asked that it be held to the smallest dollar amount possible and that the $20,000 maximum benefit be retained.

The report of the committee was accepted as amended.

Ad Hoc Committee for the Study of Health Care Delivery Systems

The minutes of a meeting of the Ad Hoc Committee for the Study of Health Care Delivery Systems on July 19, 1972, were presented by Mr. Gillen and were accepted for information.

Committee on Disaster Medical Care

The Council **approved** the change in the name of the Committee on Disaster Medical Care to the Committee on Emergency and Disaster Medical Care.

Committee on Pharmacy Relations Established

The Council voted to establish a Committee on Pharmacy Relations and empowered the President to appoint to it members of the Ohio State Medical Association and to appoint the chairman.

PSRO Council

Mr. Gillen reported to the Council with regard to a meeting of the Professional Standards Review Organization held April 19, 1972. Mr. Gillen's report was accepted for information.

Specialty Society Services

Mr. Campbell reported on a visit to the Texas Medical Association where he reviewed the specialty society program of that Association

on June 29, 30, 1972. His report was accepted for information.

Mr. Campbell was requested to reduce to writing a prototype and a suggested contract for providing specialty society services by the Ohio State Medical Association.

In this connection, a letter from the Ohio Society of Internal Medicine, expressing interest in such services, was referred to the Committee on Membership and Planning which has jurisdiction over the program to provide such services for the specialty societies.

Medical Advances Institute

A report on a meeting of the Board of Trustees of Medical Advances Institute on June 7, 1972, was presented by Dr. Henry and it was received for information.

A memorandum concerning the followup meeting on the AMA Conference on Efficient Use of Health Care Services (January 13-14, 1972, Chicago) and discussion of Peer Review Organization and Professional Standards Review Organization, held at the Ramada Inn, South, Grove City, Ohio, July 13, 1972, was presented to the Council and was accepted for information.

Ohio Medical Indemnity, Inc.

A report of the OSMA-OMI Liaison Committee was presented by Dr. Robechek and Mr. Page. The Council **approved** the Ohio Medical Indemnity revision of "A Fact Sheet Regarding the Support of Fair Fees."

Federal Legislation

The Council reviewed a communication regarding S.B. 1924 and S.J.R. 76 to expand the services of the Veterans Association Hospital System. Action on this matter was deferred pending a report from the American Medical Association on this legislation.

Report of Mr. Imboden

Mr. James Imboden, Columbus, a representative of the AMA Department of Field Service, reported on Federal legislative matters and the "Action 1972 Program" of the American Medical Association, which is being implemented in Ohio by the AMA and by the Department of Public Relations of the Ohio State Medical Association.

State Legislation

A report on state legislation was presented by Messrs. Page and Rader. The following actions of Council resulted:

S.B. 536 (Test for Gonorrhea Before Marriage) — Opposed as unnecessary.

H.B. 1215 (Public Members on Licensing Boards — Opposed.

H.B. 1220 (Licensing Emergency Medical Technologists) — Opposed to the licensing aspect.

S.B. 375 (Changing Licensure Fees) Adjustment of fees of the various licensing boards in accordance with the size of each board's budget — Active support.

Drug Labelling — Work within the existing OSMA policy.

Proposal for a Constitutional Convention — The Council expressed itself as favoring the orderly approach to revisions in the Ohio Constitution if changes are necessary. Such can be accomplished by placing alterations on the ballot by petitions initiated and signed by a prescribed number of voters or by placing amendments before the voters by a three-fifths vote of both houses of the Ohio General Assembly.

The Council, therefore, expressed opposition to the proposal to call a constitutional convention "to revise, alter, or amend the constitution," which question will be on the ballot in November.

Ohio Medical Political Action Committee

In reply to a letter from Dr. William J. Lewis, Chairman of the OMPAC, the Council agreed that members of the OMPAC Board should be given an opportunity to appear in behalf of OMPAC at the Fall Legislative Conferences. The Council also directed that the chairman of the OMPAC be given an opportunity to address the House of Delegates of the Ohio State Medical Association each year.

Communications

A communication dated June 1, 1972, from Dr. Carl G. Madsen, Jr., Painesville, was accepted for information.

A memorandum from Richard G. Layton, AMA Public Affairs Division, on current policies in the states with respect to official recognition of medical specialties on state governing boards and in the house of delegates of each state was accepted for information.

A letter dated July 14, 1972, from the Blue Cross Association, Chicago, was received for information.

Dr. Kenneth P. Turner, Logan, appeared before the Council to discuss matters involving physicians and the Government. The Council voted to commend Dr. Turner for appearing before the Council and bringing the problem to its attention.

Mr. Lang reported on studies of preschool children to determine the immunity levels in the

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First, consider who sets those policies. In a real sense, it is you. You elect the delegates to your state association. They in turn elect the delegates who will represent your views in the AMA House.

As an active, involved member, you can influence policy by making your views known to your delegates, both national and state. It is your democratic right—and responsibility.

Write your delegates, call them, see them. If they aren't responsive, tell them they'll be hearing from you at election time.

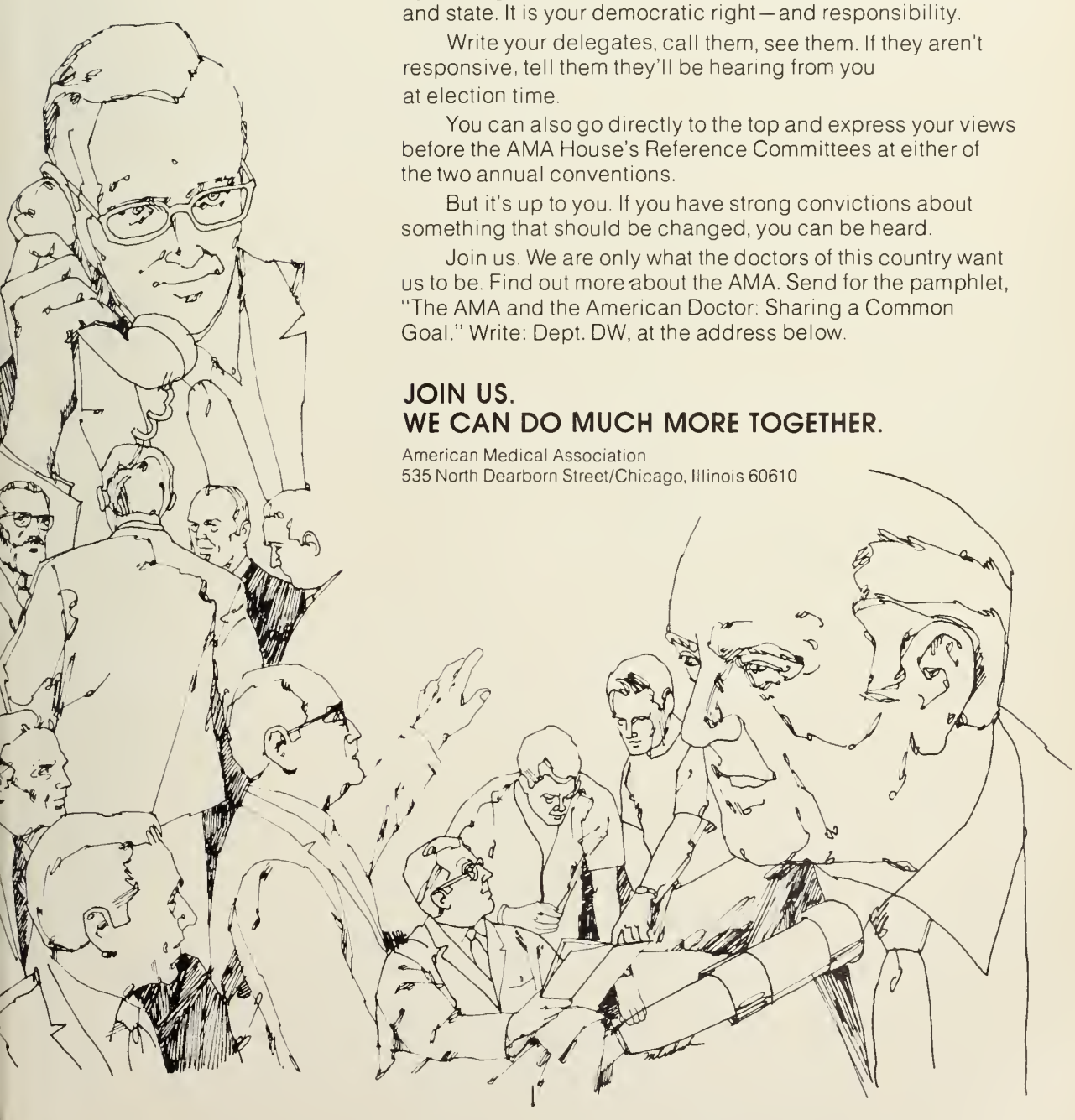
You can also go directly to the top and express your views before the AMA House's Reference Committees at either of the two annual conventions.

But it's up to you. If you have strong convictions about something that should be changed, you can be heard.

Join us. We are only what the doctors of this country want us to be. Find out more about the AMA. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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When you select this familiar antibiotic for IV infusion you have available a broad dosage rang that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomyc hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water But when 4 grams or more per day is given, Lincocin should be diluted in n less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains f pneumococci, streptococci, and taphylococci, including penicillin-esistant strains. Staphylococcal strains esistant to Lincocin (lincomycin ydrochloride, Upjohn) have been ecovered. Before initiating therapy, ulture and susceptibility studies should e performed. Lincocin has proved aluable in treating patients hyper-nsitive to penicillin or cephalosporins, nce Lincocin does not share ntigenicity with these compounds. lowever, hypersensitivity reactions ave been reported, some of these in atients known to be sensitive to enicillin.

Vell tolerated at infusion site: Lincocin ıtravenous infusions have not roduced local irritation or phlebitis, hen given as recommended. Lincocin usually well tolerated in patients who re hypersensitive to other drugs. levertheless, Lincocin should be used autiously in patients with asthma or gnificant allergies.

ı patients with impaired renal function, ıe recommended dose of Lincocin ıould be reduced to 25–30% of ıe dose for patients with normal idney function. Its safety in regnant patients and in infants ss than one month of age has ot been established.

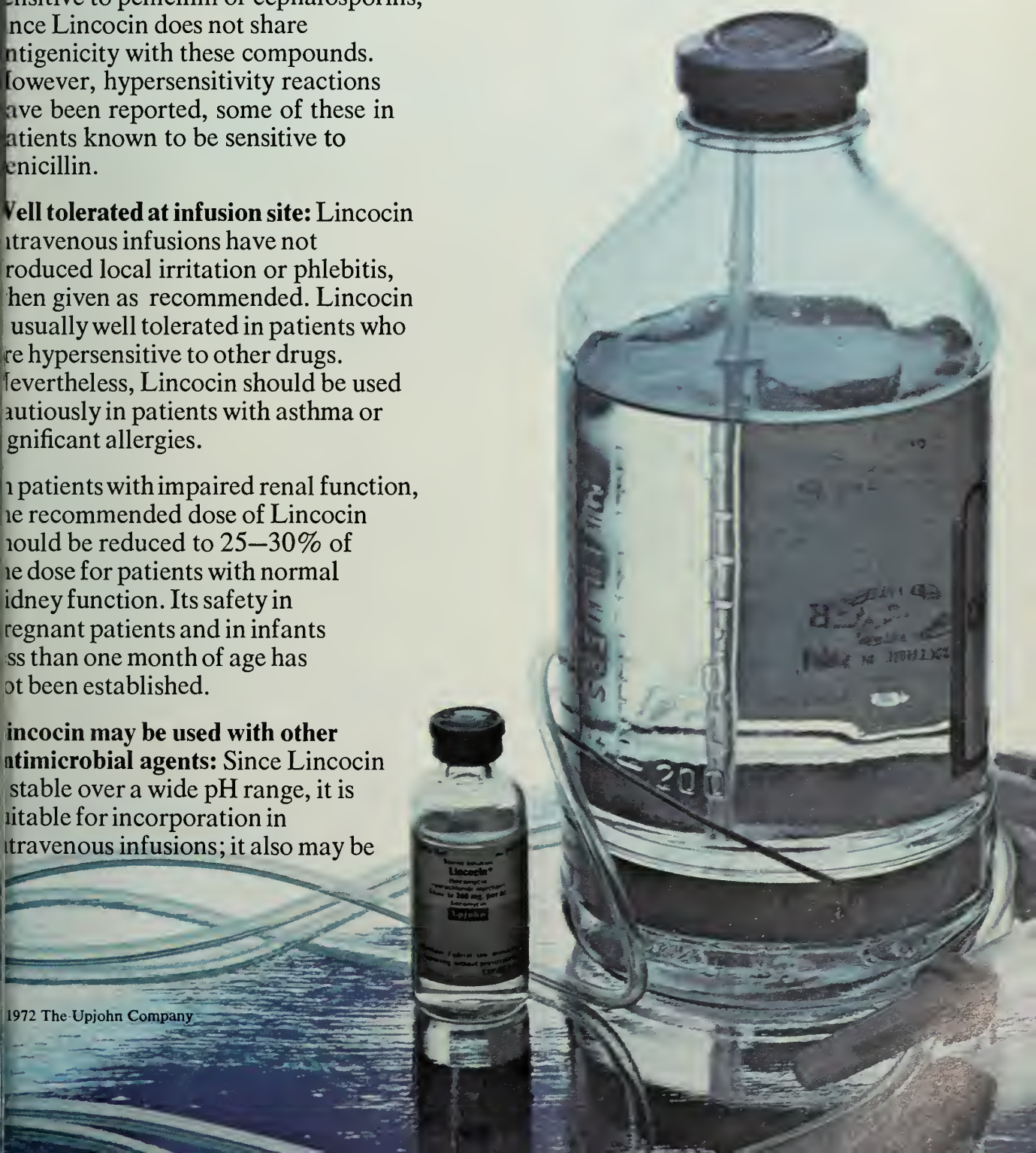
incocin may be used with other ntimicrobial agents: Since Lincocin stable over a wide pH range, it is iitable for incorporation in ıtravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatme
Skin and mucous membranes—Skin rash, urticaria, vaginitis, and rare instances of foliative and vesiculobullous dermatitis h been reported. *Liver*—Although no direct lationship to liver dysfunction is establish jaundice and abnormal liver function t (particularly serum transaminase) have b observed in a few instances. *Cardiovasc* —Instances of hypotension following pa teral administration have been report particularly after too rapid IV adminis tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adn istered IV, dilute in 500 ml of fluid administer no faster than 100 ml per h *Special senses*—Tinnitus and vertigo h been reported occasionally. *Local react* —Excellent local tolerance demonstrate intramuscularly administered Linco (lincomycin hydrochloride). Reports of p following injection have been infrequ Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in disti water or normal saline has produced local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500* Capsules—bottles of 24 and 100. *Ste Solution, 300 mg per ml*—2 and 10 ml v and 2 ml syringe. *Syrup, 250 mg per 5* —60 ml and pint bottles.

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Cleveland area with regard to all types of polio. He said that information would be forthcoming on this matter in the very near future.

Service Charges on Unpaid Accounts

A communication from the Professional Relations Committee of the Columbus Academy of Medicine regarding service charges on unpaid accounts was discussed by the Council with its legal counsel. It was the opinion of the Council that the procedure described is in violation of the Truth and Lending Act, the Ohio Usury Laws, and is not compatible with the statement of the Judicial Council of the American Medical Association entitled Professional Ideals, adopted by the American Medical Association on December 1, 1970, nor with an AMA Judicial Council statement of November 26, 1966.

Physical Examination and Record Research Services

Questions concerning several physical examination services and a service to extract information from medical records for insurance company requests were received by the Council and were referred to the Judicial and Professional Relations Committee for study and a report.

Insurance Company Prescription Limitations

The Council considered a letter of June 1 from the State Board of Pharmacy indicating that, since Schedule II non-narcotic Controlled Substance prescriptions may not be refilled, some prescribers are issuing prescriptions for several months supply to their patients. It was pointed out that many third-party underwriters limit the amount of these drugs for which they will pay to a month's supply. The Council voted to acquaint the membership with this problem and to inform the third-party underwriters that to limit payment to a month's supply contributes to increasing the cost of medical care.

Fifth Pathway

A request for discussion of the problems involving the "Fifth Pathway" was brought up by Dr. Bates in behalf of Dr. Robert N. Smith, Toledo. This matter was referred to the officers for discussion with the Medical Board.

1973 OSMA Tour Program

The Council voted to **approve** the OSMA tour program for 1973 to include trips to the South Pacific, Scandinavia, Central Europe and the Orient.

Date for Next Meeting

The next meeting of the Council will be held on September 30 and October 1, 1972.

Attest: Hart F. Page
Executive Director

Ticket Splitting May Play Big Part in Congressional Races

"*Politics,*" monthly publication of the business-industry political action committee, warns that many candidates for Congress and the State Legislature will need more than a party label to win in this coming November. It observes:

"In light of the growing number of independent voters and 'ticket splitters,' some political strategists are reevaluating the traditional belief that during a presidential election year many congressional candidates who would not win on their own are swept into office on the 'coattails' of a popular presidential candidate. Consequently, congressional candidates this year may have to win on the strength of their own campaigns.

"Reaching the independent 'swing' voters has become a priority of this year's campaigns. It is reported that the campaign managers of President Nixon have hired a leading authority on the techniques of wooing the ticket splitter. Many other candidates, perhaps as a result of the use of media managers and campaign consultants, are downplaying their party label and campaigning as individuals on specific issues."

* * *

Hoyt W. Brewster, executive director of the Utah State Medical Association, who also serves as secretary/treasurer of the Utah Medical Political Action Committee, writes in the *Utah Medical Bulletin:*

"It becomes increasingly apparent that the practice of medicine is inextricably entwined with the federal government. It also is increasingly apparent that medicine's cause can best be served through legislative influence and input. Medicine, as is the case with every vested interest group, cannot always hope to have its own way. It can, however, through the process of 'parrying and thrusting' achieve for itself battles won instead of a war lost. While many physicians are highly critical of and unwilling to participate in the UMPAC and AMPAC programs, it would seem that these provide a far better alternative than a posture of head hiding in the sand, or of indifference, or 'letting the chips fall where they may.'

* * *

Political action on the part of local physicians and their wives in support of candidates favored by the medical profession is the backbone of the medical pac movement (AMPAC and OMPAC). The workings of a candidate support committee from candidate selection to election day activities, have been gathered together in a *Handbook for Candidate Support Committees* by the American Medical Political Action Committee. It is available for limited distribution. Those involved in a candidate support committee or thinking about organizing one may obtain a copy of the Handbook by writing to OMPAC, P.O. Box 5617, Columbus, 43221.

—*Ohio Medical Political Action Committee*

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Current research efforts include cancer chemotherapy, rheumatic diseases, cardiology, dermatology, contraceptive and psychotropic products. Prior experience in these areas of research is desirable but not essential. Salaries are based on training and experience. All fees are paid by our client companies.

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Enthusiasm Greets Art Show

This Feature of the 1972 OSMA Annual Meeting Proved Popular and Revealed Widespread Interest in the Arts

THE ART SHOW proved to be one of the most popular features of the 1972 OSMA Annual Meeting in Cincinnati, both from the standpoint of participation and viewer interest. Jointly sponsored by the State Association and the Medi-Art Club of the Academy of Medicine of Cincinnati, the exhibit displayed 121 entries in the various art media. More than 50 of the pieces were entered by physician-artists. The works of doctors' wives were slightly in the majority with more than 60 of the entries produced by the ladies.

A high point in the art activities was a dinner given on Tuesday, May 9 at the Medi-Club. There, awards were presented in the form of engraved plaques to winners in four categories — painting, sculpture, photo-art, and crafts. The winners included artists from all over Ohio and wives of doctors captured six of the ten awards. Featured speaker for the occasion was Richard Boyle, curator of painting at the Cincinnati Museum of Art.

Chairman of the Art Show was Harry H. Fox, M.D., of Cincinnati, who has been producing art exhibits for several years and who has developed an art program for the Academy of Medicine of Cincinnati. Subchairman was Charles Kiefer, M.D., also of Cincinnati. Other members of the art committee were Mrs. Isaac Levine, Dr. Roland Wiseman, Dr. Sanford Blank, Dr. Samuel Rockwern, Mrs. Robert Armstrong, Dr. Phil Wasserman, and Dr. Byron Bernard. Members of the Woman's Auxiliary to the OSMA and the Cincinnati Academy also helped in the preparation and staging of the show.

Many of the exhibitors have impressive backgrounds in the art field.

Dr. Leon Goldman who took first prize in sculpture for his "Laser Lights — No 3," is a dermatologist, one of the pioneers in medical uses of the laser beam, and is director of the Laser Laboratory, University of Cincinnati Medical Cen-



With part of the art show as a background, two principals in staging the exhibit pose for the camera. Harry H. Fox, M.D., left, was chairman of the Art Show, and Charles Kiefer, M.D., was subchairman.



First Prize, Painting: "Long Shadows of War"
Mrs. Albert (Ruthie) Pearlman, Cincinnati



First Prize, Sculpture: "Laser Light No. 3"
Leon Goldman, M.D., Cincinnati



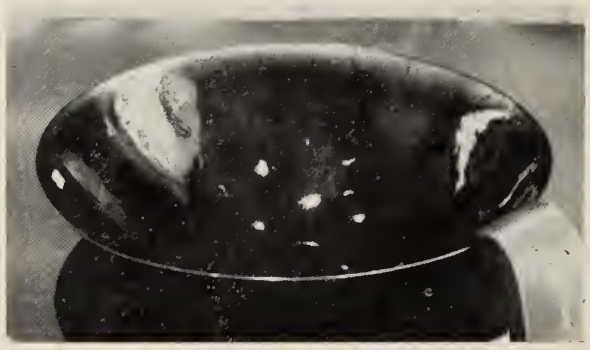
First Prize, Photo-Art: "Enter My Garden"
Marvin Aronoff, M.D., Cincinnati



Third Prize, Sculpture: "Peace Dove"
Mrs. Philip (Sylvia) Wasserman, Cincinnati



Second Prize, Painting: "When You Say That, Smile"
Mrs. Oscar (Susan) Clarke, Gallipolis



Second Prize, Crafts: "Biology Bowl"
Mrs. H. C. (Joan) Rothermel, Middletown

ter. Fascinated by the brilliant colors produced by the lasers, he became interested in applying the laser as an art medium almost six years ago.

He introduced laser carving in plexiglass and clay and on semiprecious stone. He also introduced laser photography for special effects and the development of some techniques in laser music.

Dr. Goldman entered another piece of laser sculpture, called simply "Laser Lights" in the Art Show of the American Medical Association 1972 Convention in San Francisco and won first prize in the category of advanced sculpture. He has shown sculpture and laser photography at two previous art exhibits of the Medi-Art Club in Cincinnati.

Mrs. Albert (Ruthie) Pearlman, who won first prize in painting for her "Long Shadows of War," has an impressive background in the art field. She is a graduate of the Cincinnati Art Academy, has done postgraduate work at Woodstock, New York, and has exhibited at some 14 "one man" exhibitions. She has shown her works in many museum shows, including those in Ohio at Cincinnati, Canton, Youngstown, Massillon and Dayton, as well as two Ohio print and drawing traveling exhibits.

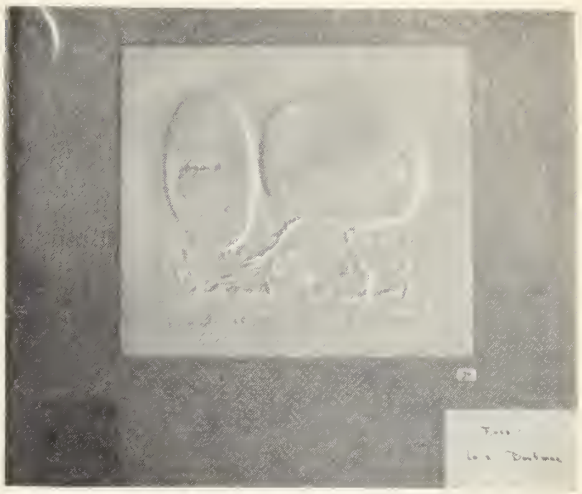
Mrs. Pearlman teaches privately at her studio and at the Cincinnati Art Museum.

Mrs. Oscar (Susan) Clarke, who won second prize in painting, traces her interest in art to a fourth grade teacher back in Montana who assigned her art projects "to keep her out of mischief." The teacher is now a professional artist. After graduating from high school, Mrs. Clarke studied for a year at the Minneapolis School of Art before attending the University of Washington where she received a B.A. degree.

Except for an occasional sketch, she deferred her art work while her family was growing up. Now she produces sporadically and sandwiches in an occasional class at the galleries in Huntington, between looking after her family, writing, and participating in projects such as opposing abusive stripmine activities in southeastern Ohio.

Artwise, vacations are her most satisfying times, and she carries both a camera and a sketchbook into the wilderness where she and her husband travel during the summer. In fact, a recent adventure of this summer took the couple down the Middle Fork of the Salmon River on a rubber raft.

Mrs. H. C. (Joan) Rothermel, who won second place in crafts for her "Biology Bowl," has an impressive background in the arts. She has a bachelor's degree in fine arts and a master's degree in art education from Miami University, Oxford. She has had additional training in art and at



First Prize, Crafts: "Fossil"
Mrs. Simon (Lois) Dorfman, Toledo



Second Prize, Photo-Art: "Homestead"
A. A. Birch, M.D., Cincinnati



Third Prize, Painting: "Crayon Batik"
Mrs. Jerry (Camille) Theobald, Cincinnati

present is enameling instructor at the Middletown Fine Arts Center.

Mrs. Philip (Sylvia) Wasserman, who won third prize in sculpture for her "Peace Dove," started sculpturing about six years ago after her children were grown. She has taken art lessons from some of the leading teachers in the Cincinnati area, and has exhibited previously at art shows of the Medi-Club. "Peace Dove" is from a piece of solid Vermont gray marble.

Mrs. Jerry (Camille) Theobald, third place winner in painting, took art as one of her minor subjects in college. She is a member of the Woman's Art Club and is fine arts chairman of the Kenwood Woman's Club.

Dr. George Garrison's "Standing Room Only" is shaped in stoneware clay, fired in a home kiln, and mounted on cork background. Dr. Garrison has dabbled for years with different art hobbies—paints, rocks, clay, but "only for my own therapy," as he puts it. In the past he has made some anatomical models. Mrs. Garrison also in an art enthusiast.

Dr. Alexander A. Birch came to Cincinnati in 1971 after serving in the Navy Medical Corps. An anesthesiologist by specialty, he has worked in the field of laser medicine and is interested in the photo-laser as well as in photo-art. He is a member of the Cincinnati Camera Club.

Dr. Marvin Aronoff, a family practitioner in Cincinnati, has studied in Europe as well as in the States. He has an impressive background in the photo art field, belongs to the Ohio Valley Camera Club, and in 1971 had a photo-art show at the Jewish Community Center entitled "Many Moods of Israel."

See the accompanying illustrations and legends for additional information on outstanding art and the artists.



Second Prize, Sculpture: "Standing Room Only"
George Garrison, M.D., Dayton

Obituaries

Hugh Amos, M.D., Cleveland and Lakewood; University of Maryland School of Medicine, 1929; aged 70; died July 24; member of OSMA and American Academy of Family Physicians; practitioner in the Cleveland and Lakewood area since 1945; veteran of World War II.

Russell J. Caton, M.D., New Smyrna Beach, Fla.; Ohio State University College of Medicine, 1913; aged 80; died July 15; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in Bucyrus from 1913 to 1956, when he retired and moved to Florida; veteran of World War I.

David Myers Creamer, M.D., Bellaire; Ohio State University College of Medicine, 1932; aged 67; died July 10; member of OSMA, AMA, and American Academy of Family Physicians; practitioner in the Belmont County area for nearly 40 years; veteran of World War II.

Arel Rolland Cunningham, M.D., Bedford; Western Reserve University School of Medicine, 1965; aged 40; died July 5; member of OSMA, AMA, American Academy of Family Physicians, and American Geriatrics Society; practitioner in Bedford for several years.

Willard Blyney Fessenden, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; aged 72; died July 1; member of OSMA and AMA; practitioner of long standing in Cincinnati where he specialized in internal medicine; veteran of World War II.

Jacob Victor Greenebaum, M.D., Cincinnati; Harvard Medical School, 1911; aged 87; died July 25; member of OSMA, AMA, and American Academy of Pediatrics; diplomate, American Board of Pediatrics; practitioner of long standing in Cincinnati where he specialized in pediatrics; associate professor, University of Cincinnati.

Charles Spencer Higley, M.D., Cleveland; University of Michigan Medical School, 1930; aged 67; died June 29; member of OSMA, AMA, and Central Society for Clinical Research; Fellow, American College of Physicians; practitioner of long standing in Cleveland, specializing in internal medicine and hematology; past president and former member of the board of the Academy of Medicine of Cleveland; veteran of World War II.

Ralph Wicks Hixson, M.D., Cleveland; Meharry Medical College School of Medicine, 1921; aged 78; died July 8; member of OSMA, AMA, and the National Medical Association; practitioner for some 40 years in Cleveland where he engaged in general practice and industrial medicine; former speaker of the House of the National Medical Association; veteran of World War I.

William E. Hoffer, M.D., Lansing, Mich.; Eclectic Medical College, Cincinnati, 1919; aged 85; died July 1; former member of the OSMA; practiced in Franklin (Warren County) and in Urbana before moving to Michigan some years ago.

William Clair Marsh, M.D., Akron; Ohio State University College of Medicine, 1940; aged 58; died February 15; member of OSMA, AMA, and American Academy of Dermatology; diplomate, American Board of Dermatology; practitioner in Akron for a number of years; formerly served with the U.S. Navy.

(Continued on Next Page)

Floyd G. Niswander, M.D., Yellow Springs; Ohio State University College of Medicine, 1942; aged 54; died June 30; member of OSMA and AMA; practitioner in Yellow Springs since 1948 and specialist in internal medicine; veteran of World War II.

Mack McKinley Shafer, M.D., Dayton; Indiana University School of Medicine, 1923; aged 75; died June 30; member of OSMA, AMA, American Academy of Occupational Medicine, and Industrial Medical Association; specialist in industrial medicine, and medical director for the Frigidaire Division of General Motors for many years before his retirement in 1959; former president of the Metropolitan Health Council, Dayton.

James Harold Smith, M.D., Maumee; University of Michigan Medical School, 1918; aged 79; died July 4; member of OSMA and AMA; practitioner in the Maumee-Toledo area from 1920 until his retirement in 1957; long a specialist in aerospace medicine as well as general practice; member of the Aerospace Medical Association; served in the U.S. Navy during World War I.

Warren Earl Unger, M.D., Alliance; Western Reserve University School of Medicine, 1918; aged 83; died July 3; member of OSMA and AMA; general practitioner for more than 50 years in the Alliance area.

Hendrik Vannak, M.D., Toledo; University of Tartu, Estonia, 1942; aged 75; died July 8 as the result of a traffic accident; member of OSMA, AMA, and American Academy of Family Physicians; came to this country in 1950 and began practice in Toledo in 1957.

Millard Wallenstein, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1906; aged 89; died July 3; member of OSMA, AMA, and American Diabetes Association; retired in recent years after a practice of long standing in Cincinnati.

Physician-Golfers Score in Annual Tournament

The Ohio State Medical Golfers Association held another successful annual tournament, this year on June 20 at the Marion Country Club. All physicians of Ohio were invited to participate, whether members of the OSMGA or not. Following the 18-hole event, a banquet was held and trophies presented, going to respective players with the low gross and low net, as well as the low gross and low net in the several age categories. Dr. C. J. Shamess, Mansfield, tournament chairman, announced the following winners:

Low Gross: 74
Bruce D. Auchard, M.D., Mansfield

Low Net: 70
Charles H. Holcomb, M.D., Richwood

In the age group 30-39
Low Gross: 76
Ralph R. Ballenger, M.D., Columbus
Low Net: 77-6 71
Jerome A. Wensinger, M.D., Marion

In the age group 40-49
Low Gross: 77
Eugene R. Turner, M.D., Middletown
Low Net: 70
Ford E. Eddy, M.D., Marietta

In the age group 50-59
Low Gross: 78
John C. Stahler, M.D., Dayton
Low Net: 82-72
Philip T. Doughten, M.D., New Philadelphia

In the age group 60-69
Low Gross: 80
Allison J. O'Brien, M.D., Fairview Park
Low Net: 86-72
Orville L. Layman, M.D., Franklin

In the age group 70-79
Low Gross: 86
Farrell T. Gallagher, M.D., Rocky River
Low Net: 106-75
Herbert W. Salter, M.D., Cleveland

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Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.

Contraindications: Diabetes mellitus that can be regulated by diet alone; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during and immediately after surgery where insulin is indispensable; severe hepatic disease; renal disease with uremia; cardiovascular collapse (shock); after disease states associated with hypoxemia.

Warnings: Use during pregnancy is to be avoided.

Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, periodic determinations of ketones in the blood and urine should be made in diabetics previously stabilized on phenformin, or phenformin and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH, and the lactate-pyruvate ratio. The drug should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis.
3. *Hypoglycemia:* Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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For complete details, including dosage, please see full prescribing information.

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of moderate to severe intensity

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- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of

pentazocine (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used w caution in patients about to undergo surgery of the biliary tra

Patients Receiving Narcotics. Talwin is a mild narcotic antagoni Some patients previously receiving narcotics have experienced m withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administe to patients prone to seizures; seizures have occurred in a few su patients in association with the use of Talwin although no cause a effect relationship has been established.

Adverse Reactions: Reactions reported after oral administrati of Talwin include *gastrointestinal:* nausea, vomiting; infrequen constipation; and rarely abdominal distress, anorexia, diarrh *CNS effects:* dizziness, lightheadedness, sedation, euphoria, he ache; infrequently weakness, disturbed dreams, insomnia, synco visual blurring and focusing difficulty, hallucinations (see *Ac CNS Manifestations* under WARNINGS); and rarely tremor, ir tability, excitement, tinnitus. *Autonomic:* sweating; infrequen flushing; and rarely chills. *Allergic:* infrequently rash; and rar urticaria, edema of the face. *Cardiovascular:* infrequently decre in blood pressure, tachycardia. *Other:* rarely respiratory depressi urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dos 1 tablet (50 mg.) every three or four hours. This may be increa to 2 tablets (100 mg.) when needed. Total daily dosage should n exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in ac tion to analgesia, aspirin can be administered concomitantly w Talwin.

Children Under 12 Years of Age. Since clinical experience in c dren under 12 years of age is limited, administration of Talwin this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have recei Talwin orally for prolonged periods have not experienced wi drawal symptoms even when administration was abruptly disc tinued (see WARNINGS). No tolerance to the analgesic effect been observed. Laboratory tests of blood and urine and of liver kidney function have revealed no significant abnormalities af prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin ov dosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and ot supportive measures should be employed as indicated. Assisted controlled ventilation should also be considered. Although na phine and levallorphan are *not* effective antidotes for respirat depression due to overdosage or unusual sensitivity to Talwin, p enteral naloxone (Narcan®, available through Endo Laboratories a specific and effective antagonist. If naloxone is not available, p enteral administration of the analeptic, methylphenidate (Ritalir may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet cont Talwin (brand of pentazocine) as hydrochloride equivalent to 50 base. Bottles of 100.

Winthrop Winthrop Laboratories, New York, N. Y. 10016 (158

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pentazocine (as hydrochloride)

the long-range analgesic

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

EACH YEAR as I write this column for the September issue of the OSMA Journal, I come up with the same lament — "low" on county news. Of course there is good reason for that state of affairs. Copy is being written early in August and August is summer time and summer time is vacation time and curtailment of activities, (auxiliary activity, that is). Moreover, the counties do not hold regular meetings during June, July and August. To be sure, just by way of example, in counties where there is a Meals Service program, that program goes on regardless of the season of the year.

Yet in spite of the dearth of county news, I do have something to write about — like our Fall Workshop and "Women In The News" (Mrs. Robert E. Pumphrey of Montgomery County). There are some pithy comments of Mrs. George Romney before the Lucas County auxiliary. There is much to be written about the new emphasis on health education. I've even discovered some belated news from Trumbull County. Somehow, in auxiliary work, one is never completely at a loss to come up with something good!

Fall Workshop

This annual Fall conference has usually been held late in September. This year it moves to the latter part of October. Mrs. Louis Loria, state president, and Mrs. Karl Ulicny, president-elect, felt the meeting could be of even greater value were the sessions held **following** the national regional workshops.

And so this important workshop for county presidents, presidents-elect and their chairmen will be held on Tuesday, October 24 at the Hospitality Motor Inn in Columbus. It will be a full, informative day — from 8 a.m. to 3:30 p.m.

Honored guest at the Fall sessions will be Effie O. Ellis, M.D, special assistant to the AMA's executive vice-president. Dr. Ellis will attend the State Board dinner scheduled for Monday evening, October 23 and later have informal discussions with Board members and any county officers who might find it possible to be on the scene that night. She will also participate in the workshops the following day. Two chairmen on the national level have been invited too — Mrs. Linus W. Hewitt, health education chairman, and Mrs. Malachi W. Sloan, II, North Central regional legislative chairman.

A remarkable 30-minute film "They're Leaving Us All the Time" will be shown at the opening of the conference. The film, narrated by Mrs. John Sugg, of North Carolina, has received honors in the International Film Festival at New York and is based on the story of the death of Mrs. Sugg's son who was killed by a drunken driver.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Bristolville, 44402

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Mrs. Ulicny who is Fall Workshop chairman has invited Mrs. Sugg to attend the meeting.

This year the sessions will run one hour each and three such sessions (each on different areas of activity, of course) will be held at one time. It is important that the counties have good representation so that there are enough county officers and chairmen to cover all the sessions. Also from Mrs. Ulicny comes word that it has been decided to use the "round table" type of workshop so that there is more time for discussion and participation on the part of the local groups.

Another workshop highlight has been announced by Mrs. S. B. Pfahl, state legislation chairman. She has invited Mrs. Emily Leedy, the Status of Women leader in Ohio, to talk on legislation for women and what our future role may be. Mrs. Leedy is director of the Women's Division of the State Employment Service.

Woman in the News

And this time I'm proud to present Mrs. Robert E. Pumphrey of Dayton, a multi-talented auxiliary member and former writer of this column. Audrey won the coveted first place ribbon (as well as a cash prize) for her painting "Diffusions In Color — Number One" at the Dayton Mall National Invitational Arts and Crafts Show held June 5 through 11. The blue ribbon award, in the acrylics class, was done with a brush on a 24 by 36 canvas in translucent tones of deep rose, pink, brown, mauve, orange and green and in an impressionistic style.

Audrey had her own 10 by 10 booth at the show which she had set up with easels, tables, etc., along with some 25 of her paintings in oils and acrylics. She had a few brush and ink sketches. Audrey tells me that she does nearly all of her own framing, although she does purchase ready-made frames.

But back to the blue ribbon painting it shows two pink pitchers, one large and one small. The larger one contains yellow flowers with orange centers on sketchy brown stems, and green leaves. There is an outline of a small bird that has to be looked for closely to be found. A small garnet-colored vase and a suggestion of an oriental vase in tones of brown are also contained in this unusual "Diffusions In Color — Number One." Congratulations, Audrey Pumphrey. We feel privileged to salute such a creative doctor's wife!

Mrs. George Romney

Back in April, Mrs. Romney spoke before the members of the Lucas County auxiliary and their guests. We did make mention of the event, but it is only recently that I have obtained Lenore Romney's pithy remarks that day. Here are some I feel are particularly worth recording:

"I think women are realizing that they should become whatever they are capable of becoming, but let's not hate men".....

"I always felt liberated but I had an awakening when I was campaigning for office. Men in the factories where I went to discuss issues would say 'get back to the kitchen, Lenore' ".....

"When the home is a center for living, for loving and for communicating, the children learn faster. All the money spent on reading and educational programs won't do any good unless the parents are taught to help the children at home. It makes all the difference in the world.".....

On industry, she had this to say: "The philosophy today is to do as little as possible. This is not the attitude abroad. Other countries can outproduce and outsell us. If we don't improve, we will have massive unemployment.". . . . . Mrs. Romney cited examples of assembly-line workers' disinterest in the good of the company and sug-



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gested profit-sharing programs as a means of increasing the individual's interest in the company for which he works.

"To achieve goals and work for social change, women must be ready to be active in politics, studying issues, endorsing candidates, and if they cannot find a candidate to their liking, even running themselves. It is an experience — not a pleasant experience — but it is an experience". . . . .

"If the goal is important enough, it is worth going through some unpleasantness to get there. If you don't accept the challenge, you are going to have to live by decisions someone else makes."

Can a woman win, she was asked? "Yes, but it's harder for a woman to win. **Many women don't trust another woman.**"

Her closing remarks — "I've been around this country enough to know that things are going to improve only if women take their share of the action." Mrs. Romney is the wife of U.S. Housing and Urban Development Secretary George Romney. Secretary Romney is a former Governor of Michigan.

Trumbull County

Mrs. Richard Hunt became the president of the Trumbull county auxiliary in May at an installation tea held in the home of Dr. and Mrs. K. P. Swisterski in Warren. Also installed were Mrs. John Schlecht as president-elect, Mrs. Frank Tracy as vice-president, Mrs. Walter Droba as corresponding secretary, Mrs. John McKay as recording secretary and Mrs. Robert Pence as treasurer. Mrs. L. A. Loria, state president, was the installing officer for her home county. Two other state officers witnessed the ceremony — Mrs. Karl Ulicny, state president-elect, and Mrs. Henry Holden, state AMA-ERF chairman.

Each year money realized from the group's annual Spring dance is distributed among various charitable and health organizations in Trumbull County to be used in some line of health or medical aid. Some ten organizations were the recipients recently of checks from the auxiliary.

Health Education

This year the emphasis of both the national and state auxiliaries is on health education. Mrs. Armin Melior, state chairman of this important project, has just sent out to all county auxiliaries "A Recommendation for a Plan of Action in Health Education." She points out that health education is not limited to knowledge about health. It is concerned with the values that determine

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one's choices and attitudes that may influence an individual's behavior.

Mrs. Melior makes these recommendations to the county groups: 1) focus on your local community; 2) select representation from the accompanying list of organizations which have indicated an interest in being involved in such a program; 3) communicate to the community what health education really is; 4) involve influential and political individuals and agencies; 5) consult with and ask for the support of the health professionals; 6) make a survey of the needs of the community; 7) investigate and list additional existing health education resources that are available but not being used; 8) develop a directory of health services in the community and make it available to the public; 9) acquaint the community with all health education plans and procedures for the greatest degree of success and the least amount of misunderstanding; 10) plan a course of study and action.

Says Mrs. Melior: "Health education boils down to what you know about health, how you feel about it and what you do about it!"

Certainly there has long been a need for such a program. The hope is that relevant health education programs can be developed in every community, for there is little doubt that every community is badly in need of intelligent and concerted health education efforts. This will require strong public and private support at the national, state and local levels. It is only through such programs of education that a turning point can be brought about for an improved quality of life for present and future generations.

Areas of particular concern are these: Aging and homebound, children and youth, mental health, nutrition, rural health and health education conferences.

Because this program is such a vital and a rather complex endeavor, it is impossible to give the full picture at one reporting. It is my hope to deal with the various aspects in more detail in future columns.

For county auxiliaries looking for a new projejct, or wanting to "update" an old one, here's a terrific and ready-made plan of action!

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

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IMMEDIATE OPENING for Ob-Gyn, Internal Medicine, and Orthopedic specialties to establish successful practice with 14-man multi-specialty group. Excellent group benefits; pension plan; modern clinic facilities; including two colleges; city population 35,000; good recreational facilities; each specialty must be board eligible or certified; young man with military obligation completed. Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

A PRIME OPPORTUNITY — For a General Practitioner in a northwestern Ohio community. New medical building available including an X-ray room and lab. Three modern hospitals within 15 to 20 miles. Complete information relative to this opportunity may be obtained by writing, Ottoville Development Corporation, Box 11, Ottoville, Ohio 45876 or phone 419-453-3610 or 419-453-3756 or 419-453-3120.

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MEDICAL DIRECTOR — opening available at multi-level care J.C.A.H. 225 bed hospital. Salary $30,000 to $34,000. For details write: Charles H. Bair, Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711.

EMERGENCY, INDUSTRIAL and/or COMMUNITY Medicine. Established southern Ohio group seeks associates with any or all of the above interests. Full or part time positions available. Ohio license required. Medical Health Services, Inc. 3801 Hauck Rd., Cincinnati, Ohio 45241 Ph. 563-1505.

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CLINICAL CHILD PSYCHOLOGIST needed for staff position in the Child Study and Treatment Department of a progressive community mental health center. Responsibilities include some psycho-diagnostic testing, consultation with other agencies, participation in community education programs, and the provision of direct therapeutic services. Family therapy skills as well as play therapy skills are highly desirable. MS/MA plus two years experience are the minimal requirements. Salary is competitive and fringe benefits are excellent. Write Robert W. Birch, Ph.D., Clinical Services Director, Muskingum Comprehensive Mental Health Center, 2845 Bell St., Zanesville, Ohio, 43701, or call (614) 452-9553. An equal opportunity employer.

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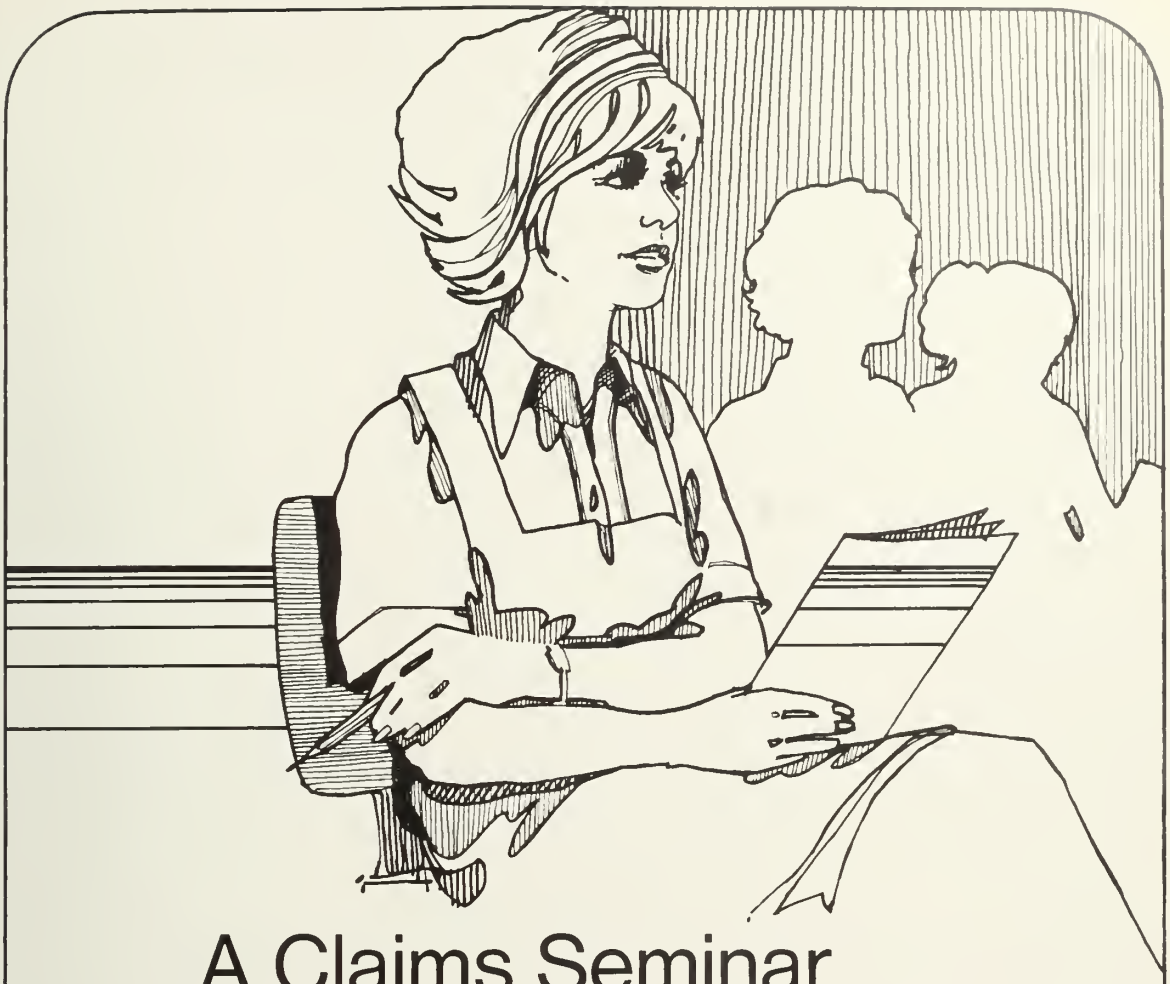
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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OCTOBER • 1972
VOL. 68 NO. 10

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

Ohio Will Host AMA Clinical Convention

FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
25 OCT 1972

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Cincinnati Exposition Center

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FRANCIS A. COUNTWAY
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Everybody experiences psychic tension.



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Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Ohio State MEDICAL JOURNAL

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Grants to Ohio State Promote Sickle Cell Studies

Two federal awards will enable the Ohio State University College of Medicine to expand research on sickle cell anemia, which strikes about one percent of the black population.

A $100,000 contract with the National Heart and Lung Institute will support a three-part study of the hereditary blood disease for one year, which started July 1, 1972.

A second and related project will test new drugs to treat sickle cell anemia. It will be supported by a $46,370 one-year grant awarded this week by the National Institute of Arthritis and Metabolic Diseases. Both Agencies are in the National Institutes of Health in the U.S. Department of Health, Education and Welfare.

Principal investigator is Dr. Stanley P. Balcerzak, director of the Division of Hematology and Oncology.

A less serious form of the disease is sickle cell trait, which affects about 10 percent of blacks in the United States, Dr. Balcerzak said. If both parents have the trait, chances are one in four that their child will develop anemia.

Research at Ohio State will focus on studying the effects of the disease on the red blood cells and finding better treatment methods. Blood samples of persons who have the anemia are needed for laboratory research. The telephone number to call is 614-422-7581, the Division of Hematology and Oncology.

The American College of Chest Physicians will hold its 38th Annual Scientific Assembly in Denver, Colorado, October 23-26. For details contact American College of Chest Physicians, 112 E. Chestnut Street, Chicago, Illinois 60611.

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Mahoning County Medical Society Dramatizes 100 Years of Medical Progress

A CENTURY OF MEDICINE in Mahoning County was the theme of the medical health building exhibits at the Canfield Fair, August 31 through September 4.

In celebrating the hundredth year of its founding, the Mahoning County Medical Society exhibited a doctor's office of 1872 along with a doctor's office of today. The older office was equipped with instruments, medicines, bottles and books used by a physician in the practice of that day. Then, doctors made much of their own medicine, using herbs which they dried and powdered themselves. The modern office contained complex diagnostic equipment available to today's physician.

For the past year the Mahoning County Medical Society has been collecting and authenticating old medical equipment and antiques. Dr. Jack Schreiber, chairman of both the Canfield Fair Committee and the Centennial Committee, stated, "We intend that this exhibition at the medical health building be the beginning of a medical museum for the community. We are certain that there is a great amount of old medical equipment still hidden in attics and garages in this area and we hope that this display will stimulate people to search out items and join us in preserving local relics of the early history of medicine."

The first physician in Youngstown, Dr. Charles Dutton, began the local history of medicine when he arrived here in 1801. His medical kit has been saved and is on display at the Arms Museum.

The Canfield Fair Board, in recognition of the centennial celebration of the Mahoning County Medical Society, has moved an old doctors office into Pioneer Village at the Fairgrounds.



Dr. Stewart G. Patton, Jr., hangs his father's shingle, just as it was when the elder Dr. Patton opened the office in North Jackson in 1913. In the picture, from left, are, Robert Hammett, president of the Canfield Fair Board; Dr. Henry Holden, president, Mahoning County Medical Society; Mrs. H. P. McGregor, widow of long-time chairman of Canfield Fair Committee of MCMS; Mrs. Stewart G. Patton, Sr., widow of Dr. Patton, Sr.; Mrs. Raymond A. Hall, daughter of Dr. Patton, Sr.; and Dr. Patton, Jr.

The office of Dr. Stewart G. Patton, Sr., built in 1913 at North Jackson, is now in place.

The building, which contains a waiting room and a treatment room, is being furnished by the Fair Board with the help of the Medical Society. Dr. Stewart G. Patton, Jr., who as a youngster spent many hours in his father's office, directed the furnishing to make everything look just as it did when the office was first opened.

Mrs. Harlan P. McGregor has contributed a roll-top desk for the office in memory of Dr. McGregor, who for many years prior to his death in 1970 was associated with the medical exhibits at the Canfield Fair. The new medical health building was dedicated in Dr. McGregor's honor in 1971.

The doctor's office has joined several buildings of the same period in Pioneer Village. It stands next to the general store which also came from North Jackson where it was located less than a quarter-mile away from Dr. Patton's office. Other buildings in the Village were originally constructed about the same time and earlier.

In the medical health building, St. Elizabeth Hospital, Youngstown Hospital Association, and Youngstown Osteopathic Hospital have joined forces to produce a hospital display showing a century of progress. The exhibit was designed to present a modern intensive care unit with all of the sophisticated equipment available in today's hospitals, next to it, the primitive intensive care of a hundred years ago.



Dr. Patton's office, complete with picket fence, garden and brick walk, in place in the Pioneer Village at Canfield Fairgrounds.



This desk with shelves is in the inner office, and shows where Dr. Patton mixed his own medicines. Hanging on the cabinet are herbs that he used.

The Heart Association presented a live demonstration showing the function of its cardiac work evaluation unit. This was in three parts: evaluation of the cardiac patient, proper exercising at the YMCA and return to work.

In other health exhibits, the American Red Cross gave a demonstration of mouth to mouth resuscitation every hour on the hour. On the half-hour, the team presented a demonstration of simple bandaging and first aid techniques.

The local chapter of the Ohio Nurses Association presented a graphic presentation of nursing services in the community. The Youngstown Society for the Blind, for the fifth year, conducted amblyopia screening for preschool children for the purpose of detecting what is known as "lazy-eye disease" in youngsters.

The Mahoning County Medical Society once again presented the American Medical Association exhibit, "Life Begins," which shows the nine month development of a baby in the mother's womb. This popular display is brought back to the Canfield Fair every other year.

Other exhibitors in the medical health building include: the Corydon Palmer Dental Society, Eastern Ohio Pharmaceutical Association, Mahoning Valley Podiatry Society, Mahoning County Veterinary Medical Association, Mahoning County Cancer Society, Youngstown Hearing and Speech Center, Mahoning Valley Kidney Foundation, Mental Health Association of Mahoning County, Tru-Mah-Col Multiple Sclerosis Society, the National Foundation, Planned Parenthood Association of Youngstown, Associated Hospital Service, the Youngstown Board of Health and the Social Security Office.

IN OHIO:

AMA Physicians' Recognition Awards

A RECENT COMMUNICATION from the American Medical Association, Department of Continuing Medical Education, lists Ohio physicians who qualified during 1971 for the AMA-sponsored Physician's Recognition Award. Details of the program were published in the November 22, 1971 issue of *The Journal of the AMA* beginning on page 1258, which announced that the awards are issued on a three-year cycle basis.

Following is the list as announced:

ALLEN (Lima)
Rene R. Santiesteban
Francisco Javier Vidal

ASHLAND (Ashland)
Darran Noel Huggins
Howard Wayne Smith
John Milton Strait, Jr.
Charles Harvey Warne

ATHENS
Henry George Croci
Athens

BUTLER
Richard Peter Burkhart
Hamilton
Aimee Wriggins
Richmond
Middletown

CLARK (Springfield)
Celerino B. Cornelio, Jr.
James Melvin Feltis, Jr.
Dale Eugene French
Sidney John Glueck

CRAWFORD
Robert Lee Solt, Jr.
Bucyrus

CUYAHOGA (Cleveland)
except as noted)
Chang Hyun Ahn
East Cleveland
L. Amaranath
John B. Anderson, Jr.
Amir Houshang Ansari
Felix Arakaki Oshiro
Niranjan Ratilal Baxi
Charles Raymond Bost
Robert E. Brooks
Parma
Diane Heiskell Browning
Kenneth Lee Burkhart
Jorge Castillo
Euclid
Asif Ali Chaudhry
John David Clough
Rogelio R. De La Roca
Ira J. Derakhshan
Chenguttai K. Dheenan
Fairview Park

CUYAHOGA (contd)
Josef Edelstein
Godrat Golkar Feilassoof
Warrensville
Gita Prem Gidwani
Parma
Belden D. Goldman
Charles Mortimer
Greenwald
Parma
Pavanender Gupta
James Lawrence Hanna
Parma
Frank Hatcher Hendricks
Rafiq A. Hussain
Jorge A. Insua
Roger Isla
Chester Joseph Janecki,
Jr.
Khemlall Khooblall
Ulrich Laux
Kyu-Duck Lee
Lakewood
George Peter Leicht
North Olmsted
Erwin Levin
Mark Roger Levine
Wai-To Liu
Walter Alan Mandell
Lene Mission-Martinez
Drogo K. Montague
Peter Nintcheff
Richard Gerhard Norby
Warrensville
Tommy Jack Poirier
Virginia C. Poirier
Reza Rezaye-Golkar
Robert S. Rosner
Luis H. Serentill
Kirtikumar T. Shah
Thimmaiah S. Shivaram
Quentin Ted Smith
Fortunata C. Somera
Lakewood
Roshan S. Talreja
Roy Henry Thompson
Don George Traul
Victor Vertes
Margaret Waisman
Sukawat Watanatittan
Donald F. Weeger
Alan Hugh Wilde

DELAWARE
Douglas L. Smith
Delaware

ERIE (Sandusky)
Donald B. Cuthbertson
Dean James Reichenbach

FRANKLIN (Columbus,
except as noted)
Joseph Sprott Atkinson
Joseph Daniel Bullock
Ronald Earl Cantor
Reynoldsburg
Saad E. El-Hawary
Robert Lloyd Friedman
John B. Gravis
John Lewis Melvin
Paul St. Clair Metzger
Robert Ross Neal, Jr.
Arnauld Nicogossian
Herbert L. Pariser
Worthington
David R. Rudy
Anthony Ruppersberg, Jr.
George T. Stine

HAMILTON (Cincinnati)
Khosrow Alamin
Robert Gregory
Armstrong
M. Balasubramanian
Nitza M. Bennett
John Edward Bossert
Chang Sig Choi
Oscar Guevara De La
Paz
Bernard U. D. De Silva
Paul E. Foldes
Roger Gresham Giesel
George William Hess, Jr.
Karol Alexander Hoffman
Harry Horwitz
Leonard Jacobson
Enrique Norberto
Kaufman
Michael Klegfeld
Robert P. Koenig
James E. McGillicuddy
Abdul Malik Mirza
Roger Dale Neal
Eileen Marie O'Ferrell
Roberto Lozano Pinon
Abbiah Narayana Reddy
Richard D. Riedel
William Steven Rutti
Irving O. Schilling
Franklin Charles
Schlueter
Edward Shmunes
Sigmund Robert
Sugarman
James S. Tan
Keith Edward Thompson
Peter Brock Wakefield
John Junior Will
Chau Wan Yan

HANCOCK (Findlay)
Herbert Adam Mahler
John Michael Mertus

HURON
Paul Eugene Burson
Bellevue
Nino M. Camardese
Norwalk
Frank Dale Crosby
Bellevue

LICKING
Lawrence Albert Dils
Granville
Turner Thomas Mills
Newark
Charles F. Sinsabaugh
Newark
Robert Swank Young
Johnstown

LUCAS (Toledo)
John Michael Osborn
Abraham Y. Sim
Daniel S. Wolff

MAHONING (Youngstown,
except as noted)
William Robert Cook, Jr.
Chia Koon Lee
Maria Mu-Lien Liang
Fok
Joseph Mersol
Struthers
Henry L. Shorr

MIAMI
Edward Helmuth Kirsch
Piqua
Marcus Miller
Covington

MONTGOMERY (Dayton,
except as noted)
Mazhur Hussain
Chaudhry
David Allen Garrety
Phillipsburg
Gordon Lee M. Gibson
Norbert L. Kosater
George W. Markus
Arthur Paul McDonald
Edward J. Sheridan III
Wright-Patterson AFB
Philip Owen Shriner
Richard J. Sievers
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PORTAGE
Victor Manuel Garza
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Kent
George Rudolph Sprogis
Hiram

(Continued on Page 916)

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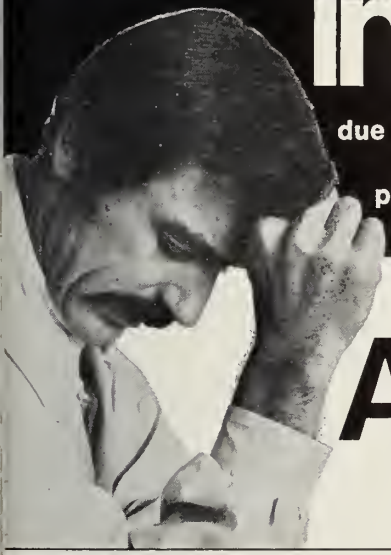
The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
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Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

REFER TO PDR

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.
Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evangelista, L. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestostereoe-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermategenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 26). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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AMA Recognition Awards *(Contd.)*

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Charles Orval Butner
Shiloh
James D. Curry
Mansfield
S. K. Sekaran
Mansfield

SCIOTO
John S. Temponeras
Portsmouth

SENECA
Edmund F. Ley
Tiffin

STARK (Canton, except as noted)
Guillermo Andrade Flor
Robert Kline Gardner
Shirley W. Gregory
Hyung Wook Kang
Cornelio P. Katubig
Joseph W. Kolp
William Emery Sag
Rauf Zihni Unver

SUMMIT
Eunice E. Runner Carter
Cuyahoga Falls
David Goddard Dye
Akron
Arnold Leo Peter
Akron
John Albert Soquel
Cuyahoga Falls

TRUMBULL (Warren)
Luis Enrique Cali
Ludgerio Zabala Claustro
Irvine George
Milheim, Jr.
Robert Joseph Paul

WARREN
Thomas E. Fox
Mason

Four Grants in Ohio Will Combat Drug Abuse

The White House Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health announced recently that 54 new grants totalling $31,327,055 have been funded to provide treatment and rehabilitation services for narcotic addicts and other drug abusers in communities throughout the United States.

The following grants were made for programs in Ohio:

Central Community Health Board, Cincinnati, $203,413.

Columbus-Franklin County Comprehensive Drug Program, $879,012.

Dayton Mental Health Center Comprehensive Drug Dependency Treatment Program, $848,243.

A staffing grant of $1,514,099, for comprehensive treatment and rehabilitation service programs, went to Community Action Against Addiction, Drug Abuse and Addiction Program, Cleveland.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

CEREBRO-NICIN® double-blind study* shows how some senile symptoms can be treated. Four times as many aging patients showed striking improvement.

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.



"For generations my family has insisted on Donnagel®-PG," says active young matron Mrs. T. Farnsworth Lipp (of the Upper Lipps), shown here with her charming son. "All the benefits of paregoric—without the unpleasant taste, don't you know? And Junior thinks Donnagel-PG tastes so much like bananas that I never worry about a slip between spoon and Lipp."

A Matter of Taste

With or without a silver spoon, a most tasteful solution in treating acute, non-specific eas: all the benefits of paregoric, without the unpleasant taste. Donnagel®-PG treats ıpanying cramping, tenesmus, and nausea as well as the diarrhea itself. Instead of ısant-tasting paregoric, it contains the therapeutic equivalent, powdered opium, ɔmote the production of formed stools and lessen the urge. And it provides the cent-detoxicant effects of kaolin and pectin, plus the antispasmodic benefits of onna alkaloids. And a good banana flavor to baby any taste.



Donnagel®-PG

Donnagel with paregoric equivalent

℞ Available on oral prescription or without prescription under limited circumstances as modified by applicable state law.

ach 30 cc. contains: Kaolin, 6.0 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; ne sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Powdered opium, USP, 24.0 mg. alent to paregoric 6 ml.) (Warning: may be habit forming); Sodium benzoate (preservative), g.; Alcohol, 5%. A.H. Robins Company, Richmond, Virginia 23220

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The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

Robitussin®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Alcohol, 3.5%

For unproductive allergic coughs

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Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
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Non-narcotic for 6-8 hr. cough control

Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Dextromethorphan hydrobromide ..... 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough

Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate ..... 100.0 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

Cough Calmers®

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Glyceryl guaiacolate ..... 50.0 mg.
Dextromethorphan hydrobromide ..... 7.5 mg.

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Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.

Robitussin® extra benefit chart	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®					●
ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●		●		●
ROBITUSSIN-PE®				●	●
COUGH CALMERS®	●		●		●

A. H. Robins Company,
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A·H·ROBINS



When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in no less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

ifections caused by susceptible strains
pneumococci, streptococci, and
aphylococci, including penicillin-
sistant strains. Staphylococcal strains
sistant to Lincocin (lincomycin
ydrochloride, Upjohn) have been
covered. Before initiating therapy,
ulture and susceptibility studies should
performed. Lincocin has proved
luable in treating patients hyper-
nsitive to penicillin or cephalosporins,
ince Lincocin does not share
tigenicity with these compounds.
owever, hypersensitivity reactions
ve been reported, some of these in
tients known to be sensitive to
nicillin.

ell tolerated at infusion site: Lincocin
travenous infusions have not
oduced local irritation or phlebitis,
nen given as recommended. Lincocin
usually well tolerated in patients who
e hypersensitive to other drugs.
evertheless, Lincocin should be used
utiously in patients with asthma or
nificant allergies.

patients with impaired renal function,
e recommended dose of Lincocin
ould be reduced to 25—30% of
e dose for patients with normal
dney function. Its safety in
egnant patients and in infants
s than one month of age has
t been established.

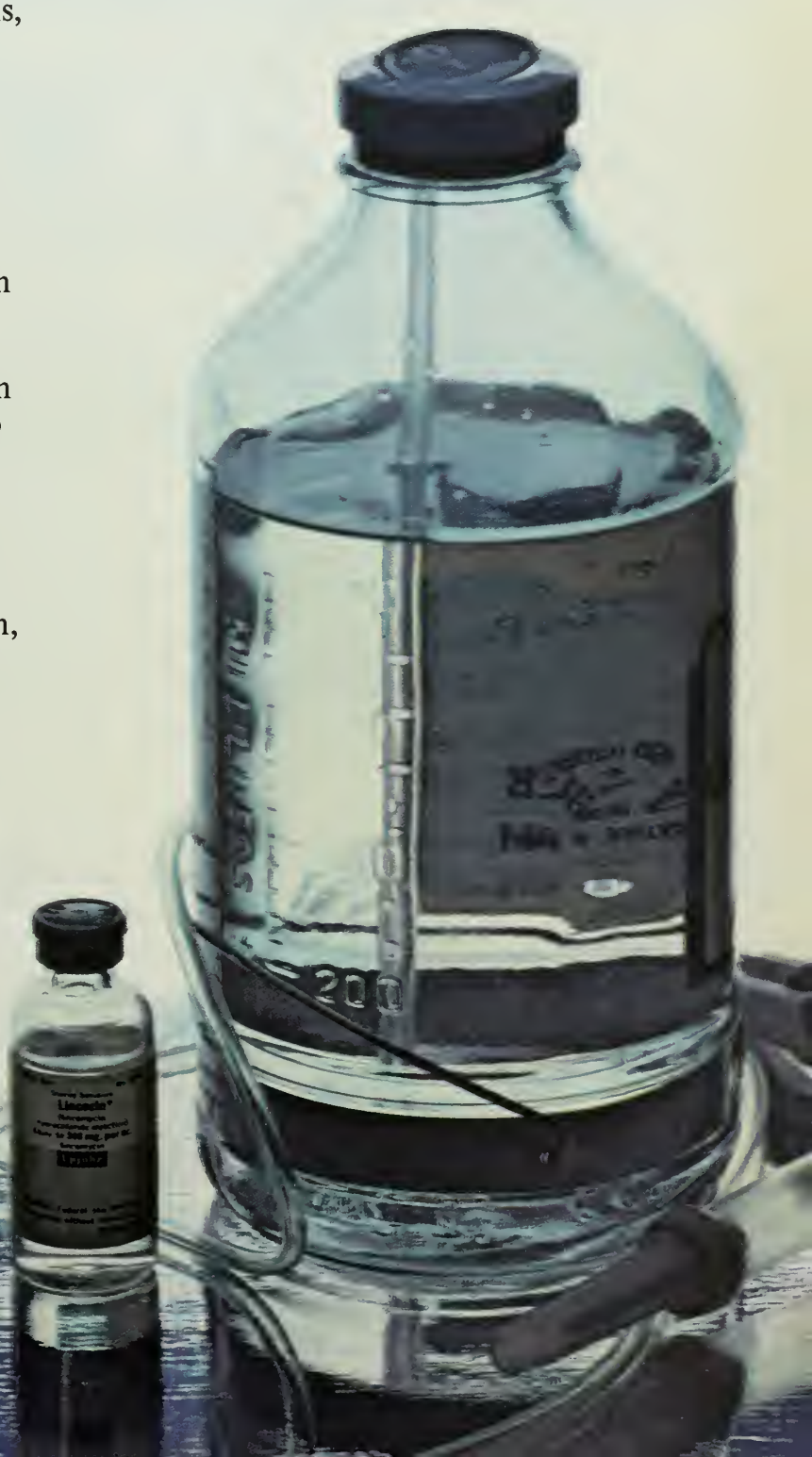
ncocin may be used with other
timicrobial agents: Since Lincocin
table over a wide pH range, it is
table for incorporation in
ravenous infusions; it also may be
administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



972 The Upjohn Company



Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatm *Skin and mucous membranes*—Skin ras urticaria, vaginitis, and rare instances of foliative and vesiculobullous dermatitis h been reported. *Liver*—Although no direct lationship to liver dysfunction is establis jaundice and abnormal liver function t (particularly serum transaminase) have b observed in a few instances. *Cardiovasc* —Instances of hypotension following pa teral administration have been repor particularly after too rapid IV adminis tion. Rare instances of cardiopulmonary rest have been reported after too rapid administration. If 4.0 grams or more adr istered IV, dilute in 500 ml of fluid administer no faster than 100 ml per h *Special senses*—Tinnitus and vertigo h been reported occasionally. *Local react* —Excellent local tolerance demonstrate intramuscularly administered Linco (lincomycin hydrochloride). Reports of following injection have been infrequ Intravenous administration of Lincoci 250 to 500 ml of 5% glucose in dist water or normal saline has produced local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500* Capsules—bottles of 24 and 100. *St Solution, 300 mg per ml*—2 and 10 ml and 2 ml syringe. *Syrup, 250 mg per* —60 ml and pint bottles.

For additional product information, co the package insert or see your Upj representative.

MED B-6-S (KZL-7) JA71-1

The Upjohn Company
Kalamazoo, Michigan 49001

Upjo

American Medical Women's Association To Meet in Columbus, Nov. 11-14

OHIO WILL HOST the annual meeting of the American Medical Women's Association and an Ohio physician will preside as president of the organization. The meeting is scheduled at the Christopher Inn, in downtown Columbus, November 11-14.

Dr. Frances K. Harding, Columbus, is president of the national organization and will preside at official sessions. She was named president-elect in 1970 and installed as president at the 1971 annual meeting in New Orleans.

Dr. Ruth Fleming, of San Francisco, was named president-elect at the last meeting and will be installed as president at the final business session in Columbus.

Dr. Harding is a practicing physician in Columbus, specializing in obstetrics and gynecology. She is the wife of Dr. Warren G. Harding 2nd. Since assuming the presidency of the 6,000-member organization she has spoken numerous times in behalf of the goals set by the group.

The August 28 issue of the *American Medical News* contained an illustrated article reporting an interview with Dr. Harding under the title "Bright Future Foreseen for Woman Physicians." One of the AMWA's main goals is to achieve more representation for women on councils and committees of the American Medical Association and other national associations. Readers will remember that the Ohio delegation introduced a resolution at the 1971 Clinical Session of the AMA, emphasizing the right of female physicians with respect to policy making positions in medical organization.

The resolution, passed by the AMA House of Delegates, in part stated "that the AMA recognize the high professional and civil qualifications of many female physicians and as a matter of policy encourage their election and appointment to positions of importance within and outside the Association" . . . and further . . . "that the AMA urge state and local medical societies to similarly recognize the important role female physicians can play in their organizational structure . . ."

The *American Medical News* points out that more women are being admitted to medical schools. Data at the time showed that one of every ten medical students was a woman, but of the entering class of medical schools in 1971, 13 percent of students were women. AMWA has set up a scholarship and loan fund providing financial aid to talented women students who are seeking careers in medicine.



Frances Harding, M.D.

The *American Medical News* article of August 28 was one of two features on women physicians. The other was an article entitled, "In 'Man's World,' She's Happy and Successful," featured Dr. Janet K. Bixel, of Worthington and Columbus. She and her husband Gordon have a family of five children.

It is estimated that the membership of AMWA constitutes about one-fourth of the practicing women physicians in the country. It has 52 branch organizations nationally and 21 junior branches at medical schools across the country. The AMWA is affiliated with the International Medical Women's Association, the oldest international medical association in the world.

Additional information will be published on the national meeting in Columbus and members of the organization will receive direct communications from the planning committee.

The Physician's Inventory of His Own Continuing Medical Education

An Ohio Study

Synopsis — The purpose of this study was to determine the continuing education needs and preferred educational methods of selected Ohio physicians. While the continuing medical education needs of responding physicians were widespread the endocrinological, metabolic and hemopoietic area of medicine was most in need of educational attention. The need for continuing education is strong in all medical specialties but psychiatry, internal medicine and pediatrics expressed the greatest needs. Responding physicians want more opportunities to use individual, visual communications and face-to-face methods such as programmed instruction, medical television and group discussion. The general education interests of the responding physicians are related to the particular developmental tasks with which they are primarily concerned at their stage of life.

ADULT EDUCATION will effect behavior change to the extent that programs are designed to meet the needs, interests and desires of the clientele it serves. As Dutton[1] has pointed out this implies that the clientele must have a part in designing the educational process. However, John W. Williamson, M.D. and George F. Miller, M.D.[2] of the University of Illinois College of Medicine indicate that such involvement does not characterize any large number of contemporary programs of continuing medical education. They state that many continuing medical education programs "seem more often to reflect the interests of the teachers than the needs of the learners and to use techniques that are familiar or appealing but not necessarily the most appropriate to the task."

There is a constant need for those working in continuing medical education to examine their program planning procedures in order to establish objectives which are in line with the needs of the practicing physicians who are their clientele. A better understanding of the physicians themselves and their educational needs and preferred methods enables professors of medicine, directors of continuing medical education and other adult educators to plan programs that will be more meaningful to the physician learners.

In January, 1970 such an examination was undertaken in the form of a cooperative venture to inventory the continuing medical education needs of selected physicians in the state of Ohio. The inventory was conducted by the Center for Continuing Medical Education and the Ohio State Regional Medical Program of the College of Medicine at The Ohio State University. A questionnaire was mailed to the nearly 9,000 physicians on the mailing list of the Center for Continuing Medical Education. There were 2,218 usable questionnaires returned representing a response of 25 percent of physicians contacted.

The intent was to obtain the following information:

1. The personal and professional characteristics of the physicians.
2. The physician's self-perceived continuing medical education needs in various clinical conditions and in nonmedical general education areas.
3. The educational methods used or needed by the physicians.

This article presents the results of the inventory. The results of the inventory were tabulated and placed on computer tape at The Ohio State University College of Medicine.

Respondents

The typical physician who responded to the questionnaire was a married male 46 to 55 years of age who has been in solo practice for 16 to 25 years. He is a board certified family practice physician providing health care in a population area of over 50,000 people. He is affiliated with one or two hospitals ranging in size from 100 to 500 beds. The physicians who responded to the question-

The Authors:

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naire are not necessarily representative of all physicians in Ohio. They do, however, represent a group of physicians on the mailing list of the Center for Continuing Medical Education who apparently have an interest in continuing education.

Clinical Management Conditions for Which Educational Assistance Is Needed

Eight out of ten of the responding physicians indicated some degree of need for educational assistance in all 120 clinical management conditions inventoried.

The responding general practitioners' top five ranked clinical conditions in need of educational attention were:

- Rheumatoid arthritis and osteoarthritis
- Cardiac arrhythmias
- Diabetes mellitus
- Chronic bronchitis and emphysema
- Hypertensive cardiovascular diseases

Responding surgeons indicated greatest educational needs for the following conditions:

- Cholelithiasis
- Neoplasm of colon and rectum
- Duodenal ulcer
- Gastric ulcer
- Diverticulosis

Internal medicine specialists ranked the following clinical conditions in their top five in terms of educational need:

- Cardiac arrhythmias
- Diabetes mellitus
- Hypertensive cardiovascular diseases
- Chronic bronchitis and emphysema
- Myocardial infarction

All five top ranked conditions for responding obstetric and gynecological specialists were in the obstetric and gynecological area of medicine:

- Disorders of menstruation
- Female sterility
- Disorders of uterus, vagina and vulva (non-venereal)
- Menopausal disorders
- Neoplasm of female genitalia

Responding pediatricians' top ranked conditions in terms of educational need were:

- Management of newborn
- Acute upper respiratory infection
- Bronchial asthma
- Congenital heart
- Epilepsy

(Continued on Next Page)



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Physician's Inventory *(Contd.)*

All five top ranked conditions for responding psychiatrists were in the psychiatric area of medicine:

- Character and behavior disorders
- Anxiety reactions without somatic symptoms
- Psychoneurotic somatization reaction affecting digestive system
- Sexual psychopathy
- Psychoneurotic somatization reaction affecting circulatory system

Needed Methods of Continuing Education

The one educational method that ranked highest in terms of being **needed but not available** to the responding physicians is a face-to-face type method:

- Group discussion (seminars and study groups)

The next seven most needed but not available methods are a combination of individual instruction and visual communication:

- Programmed instruction
- Medical television
- Video tape recordings
- Computer assisted instruction
- Demonstrations
- Supervised clinical practice
- Medical radio (Ohio Medical Education Network)

These eight methods listed above were ranked highest in terms of not being available but needed by responding physicians in all years of practice categories, in all types of practice organization, in all medical specialties, in all population areas and for responding physicians affiliated with hospitals of all sizes.

Physician General Education Preferences

The five general education topics or goals of greatest interest to responding physicians were a combination of public affairs education, science education, finance education, and home and family life education:

- Studying problems facing the country domestically and internationally
- Developing an understanding and knowledge of public issues
- Developing a reasonable amount of scientific knowledge
- Developing an understanding of investments
- Developing an understanding and knowledge of family living

Conclusions

The continuing medical education needs of responding physicians are widespread in that they cover nearly all medical specialties surveyed and clinical management conditions in nearly all areas of medicine. The endocrinological, metabolic and hemopoietic area of medicine ranked highest in terms of clinical conditions for which educational help is needed. This area is followed by, in descending order, respiratory, gastroenterological, cardiovascular, psychiatric, obstetrics and gynecological and sensory and neurological areas of medicine.

While the need for continuing education is relatively high for all responding specialties, psychiatrists, internal medicine specialists and pediatricians seem to have expressed the highest degree of need. Continuing education needs for the various clinical conditions vary from medical specialty to medical specialty. Responding general practitioners and internal medicine specialists have similar continuing education needs while responding surgeons, pediatricians, psychiatrists, obstetricians and gynecologists have rather unique needs peculiar to their specialties.

Responding physicians from all specialties, all years of practice categories, all types of practice organization, all population areas and all responding physicians affiliated with all sizes of hospitals want more utilization of individual, face-to-face and visual communication methods in their continuing education programs.

Like other adults, the responding physicians have general education interests that are related to the particular developmental tasks with which they are primarily concerned at their stage of life.

Implications for Programming in Continuing Medical Education

Data from this study indicate that continuing medical efforts in the near future should include programming in the following areas of medicine: endocrinology, metabolic, and hemopoietic: gastroenterology, respiratory, and musculoskeletal. Continuing education programs should be planned for specific medical specialties. Immediate attention should be given to the specialties of psychiatry, internal medicine and pediatrics. Continuing education programs should include a variety of methods. Every attempt should be made to see that opportunities for individual, face-to-face and

visual learning experiences are included in as many educational activities as possible.

As pointed out earlier the practicing physicians must have a part in designing the educational process utilized in their continuing medical education programs. This means that data from studies such as the one just described are essential but the data cannot be used to plan programs in the vacuum of the medical center. Planning meetings involving the medical faculty, practicing physicians and adult educators must be conducted eight to twelve months in advance of program dates so that specific educational objectives, content, faculty, technique and evaluation procedure can be cooperatively planned.

If university medical centers are to remain effective in their efforts to keep physicians abreast of their own professional areas, they must design their programs to meet the changing needs and interests of practicing physicians. A sequel to this article will show how this and other studies were implemented in designing meaningful continuing medical education programs.

References

1. Dutton, Donnie, Should the clientele be involved in program planning? *Adult Leadership* 19:181-182.
2. Williamson, John W., and Miller, George E., Continuing medical education Priority Project—final report, University of Illinois, 1966, p. 1 (mimeographed)

The 14th postgraduate medical seminar cruise sponsored by the Department of Postgraduate Medicine, Albany Medical College is scheduled for January 5-22. The 11-day cruise from New York will be aboard the Swedish American Line ship *Gripsholm*. For details, write Frank M. Woolsey, Jr., M.D., Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

A one and a half day scientific meeting of the American Rheumatism Association Section of The Arthritis Foundation will take place at the Pittsburgh Hilton Hotel on December 8 and 9. For further information contact Miss Lynn Bonfiglio, Executive Secretary, American Rheumatism Association Section, The Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.



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Continuing Education Opportunities for Physicians in Ohio

Surgical Seminars — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

Clinical Days on Emergency Care — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

Introductory Course in Nuclear Medicine for Physicians — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

October

Group Psychotherapy, Ohio State University, October 6 through December 22 (26 hours).

Annual Cancer Symposium sponsored by the American Cancer Society, at Scot's Inn Motel, Columbus, October 11, 9:00 a.m. to 4:00 p.m. Contact, American Cancer Society, Ohio Division, 1367 East Sixth Street, Cleveland 44114.

An Introduction to Transactional Analysis, Akron City Hospital, 525 E. Market Street, October 11, beginning at 8:30 a.m.; Thomas R. Riley, M.D., and Raymond S. Federman, M.D., coordinators.

Tri-State Regional Meeting (including Ohio), American College of Physicians, October 13-14, Motel Heart of Town, Charleston, W. Va.; contact Jack D. Baur, M.D., 1115 20th Street, Huntington, W.Va. 25703.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Advanced Executive Management Institute for Health Services Administration — Sponsored by OSU College of Medicine, October 16-20, at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

Differential Diagnosis of Blood in the CSF, and Curiosities of Behavior in Some Organic Neurological Disorders — Youngstown Hospital Association, Medical Division meeting, at the South Unit, October 19, 8:00 a.m.; guest professor, John P. Conomy, Jr., M.D., assistant professor of neurology, Case Western Reserve University.

Stroke Rehabilitation — University of Cincinnati College of Medicine (CONMED), at the Shrine Burns Institute, Cincinnati, October 19-20.

Rheumatoid Arthritis, University of Cincinnati Medical Center, (CONMED), October 19-20.

Association of Physicians of the State of Ohio, quarterly meeting, October 20, Juvenile Diagnostic Center, Columbus; contact Virginia Edwards, M.D., 374 Lexington Avenue, Mansfield 44907.

Surgery of Coronary Artery Disease – Youngstown Hospital Association; Surgical Division meeting at the South Unit, October 24, 9:00 a.m.; speaker, Dan W. van Heeckeren, M.D., associate professor of thoracic surgery, Case Western Reserve University.

Diabetes Conference — Sponsored by OSU College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Rd., Columbus; October 25; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

Current Therapy III — Infectious Diseases — Third Annual Postgraduate Medical Seminar sponsored by the Scioto County Medical Society; Thursday, October 26, at the American Legion Hall, 705 Court Street, Portsmouth.

Postgraduate Seminar in Adolescent Psychiatry — Sponsored by OSU College of Medicine, at the Granville Inn, Granville, October 27-28; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

November

Principles of Surgical Physiology — Joint meeting of Cleveland Society of Obstetricians and Gynecologists and the Cleveland Surgical Society; November 1, beginning at 3:00 p.m. in the Bunts Auditorium of the Cleveland Clinic, 9500 Euclid Ave., Cleveland; contact Kathryn E. Hoffman, M.D., 806 Rose Bldg., Cleveland 44115.

Medical and Surgical Treatment of Recurrent Pelvic Cancer — Youngstown Hospital Association, All Divisions meeting, at the South Unit, November 2; speaker, Lester A. Ballard, Jr., M.D., assistant clinical professor of obstetrics and gynecology, Case Western Reserve University.

Vascular Disease Symposium — Sponsored by OSU College of Medicine, at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus, November 3-4; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

(Continued on Next Page)



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American Urological Association Postgraduate Seminar — Western Reserve University, Cleveland, November 4-6.

A Conceptual Approach to Stroke Rehabilitation — Akron City Hospital, 525 E. Market St., Akron 44309; November 8.

Ophthalmology for the Generalist — Sponsored by University of Cincinnati College of Medicine (CONMED), at Shrine Burns Institute, November 9.

Gastroenterology — Current Topics — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; November 15-16.

Hyponastremia — Causes and Management — Youngstown Hospital Association; Medical Division meeting at the South Unit, November 16, 8:00 a.m.; speaker, J. Dennis Morton, M.D., clinical instructor in medicine, Case Western Reserve University.

Scientific Basis of Newborn Care — Sponsored by the American Academy of Pediatrics, at the Shrine Burns Institute, Cincinnati, November 16-18.

Symposium on Advocacy for the Mentally Retarded and Developmentally Delayed — Sponsored by OSU College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 20-21; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

December

Cardiovascular Conference — Sponsored by OSU College of Medicine, at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus, December 1; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

Intensive Care Monitoring of the Seriously Ill Patient — Youngstown Hospital Association, Surgical Division meeting, at South Unit, December 2, 9:00 a.m.; speaker, Robert M. Zollinger, Jr., M.D., associate professor of surgery, Case Western Reserve University.

Current Concepts in Ophthalmology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; December 6-7.

A Day of Gastroenterology — Akron City Hospital, 525 E. Market St., Akron 44309, December 13.

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"The history of science, and in particular the history of medicine ... is ... the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

13.8%
Do not believe combination drug products are useful.

Are combination drug product useful in treatment involvin concomitant use of two or more drugs

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only hy examining tbe advantages and disadvantages in the individual case.

Among tbe advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as tbey are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of tbe formulation sbould be demonstrated in the laboratory and clinic before the product is available for prescription–which is more than can usually be said for tbe physician's own spontaneous creations. And, tbe dosage ratios employed in rational precompounded combinations are designed to meet tbe needs of substantial numbers of "typical" patients.

Tbere is no doubt tbat many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But tbat hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage tbat comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin hut forget tbat a certain analgesic mixture, wbich be knows only by its trade name, contains aspirin. His prescription, tben, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination tberapy as sucb. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is tbat they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be tbe most effective choice. A good example of tbe usefulness of combinations appears in a recent article in tbe *Journal of Chronic Diseases* on tbe efficacy and side effects of an antihypertensive containing tbree ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, wbether the drugs were given individually or togetber, incidence and severity of side effects were tbe same. But blood pressure control was invariably better when tbe drugs were taken in one combination tablet tban wben they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding whicb combinations constitute rational tberapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewbat differently if tbey are old and establisbed or new and untried.

In today's regulatory atmospbere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in tbe form of controlled trials tbat show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that bave been around for a long time. In other words, physician acceptance over a long period should he given some weight as evidence of the efficacy and safety of these drugs.

The FDA, bowever, does not seem to share tbis attitude. It often requires, for these older products, controlled trials that will monopolize tbe time of already overtired investigators and cost a great deal of money. I wish we could agree on a "grandfather clause" approach to preparations that have been in use for a number of years that have an apparently satisfactory track record.

For example, I think some of the antibiotic combinations that were taken off the market by the FDA performed quite well. I am thinking particularly of penicillin - streptomycin combinations that patients – especially surgical patients – were given in injection. This made much less discomfort for the patient, less demand on nurses' time, and fewer opportunities for dosage errors. To take such a preparation off tbe market doesn't seem to be good medicine, unless actual damage sbowed a great deal more barm from tbe injection (rather than the proper use) of the combination.

The point that should be emphasized is that there are both rational and irrational combinations. The real question is, who should determine wbicb is which? Obviously, the FDA must play a major role in making this determination. In fact, I don't think it can avoid taking tbe ultimate responsibility, but it should enlist the help of outside physicians and experts in assessing the evidence and in making tbe ultimate decision.

Maker of Medicine

F. Clarke Wescoe, M.D.
President
Sterling-Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of philantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he imputes a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the *usual* dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

What is your opinion, doctor?
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Are You Prepared to Vote Wisely on November 7?

It is suggested that you check with the officers and legislative committeemen of your County Medical Society regarding the qualifications of candidates running in the November 7 General Election . . . . Only an informed voter will be able to vote wisely.

* * * *

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* * * *

"The words of Plato have never been more appropriate: 'The punishment of wise men who refuse to take part in the affairs of government is to live under the government of unwise men'." —*Oregon Medical Political Action Committee Bulletin.*

* * * *

"I know many of you are so concerned whenever anybody suggests that you get into politics, and I do not speak in any partisan sense. I am not concerned about whether you are in politics in one party or the other. The main thing is to be in. I have heard a doctor say on occasion: 'I am only interested in my profession; I am not interested in politics'. Let me tell you something: He bette· get interested in politics or he won't have any profession to be interested in. And I am not referring just to politics to defend your profession. You should do that. Defend what is best in it. Correct what needs to be corrected. But I am referring to politics in the broader sense of leadership."—*President Nixon in speech at 1971 AMA meeting, Atlantic City.*

* * * *

"How the problems are resolved will, to a great extent, be determined by who the legislators are who will do the legislating. We are far more likely to emerge with good laws if good and thoughtful legislators sit in the halls of Congress, and we are far more likely to develop and keep such legislatures if the PAC movement continues its unremitting effort to help them win election." —*George J. Lawrence, Jr., M.D., former chairman of AMPAC Board.*

* * * *

"AMPAC is not a physician's excuse for inactivity. Membership in AMPAC does not fulfill an individual's political responsibility. AMPAC is a catalyst. It brings together the forces of physicians, their wives, families and friends, into one strong, effective organization. It gives added strength and effectiveness to the individual effort. It provides you with the only existing opportunity to concentrate your support on a nationwide basis."—*Excerpt from talk by Frank C. Coleman, M.D., former member of AMPAC Board.*

—*Ohio Medical Political Action Committee*

Medical College at Toledo Starts New Class of 48

The Medical College of Ohio at Toledo accepted 48 students for the class that opened September 11. The incoming students were chosen after competition from more than 2,000 applicants. Those selected represent a broad spectrum of backgrounds and interests.

Some have had experience in the Air Force, Peace Corps, Army and Coast Guard. Many entered MCO directly after completing baccalaureate programs mostly in biology, psychology, zoology or chemistry. A few have earned master's and Ph.D. degrees in health-related fields.

There are five women and 43 men in the entering class. Forty-six are permanent residents of Ohio. Six are from Toledo, five from Columbus, six from Cleveland and vicinity, and two each from Dayton and Youngstown. The remaining Ohioans come from 25 different cities.

The 48 entering students mark the fourth class to be admitted to the Medical College of Ohio, and the second class with 48 students.

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Clinical & Scientific Features



Volume 68 October 1972 Number 10

Immobilization Time for Closed Fractures in Children

A Review of 290 Patients

Edward J. Eyring, M.D.

THE LENGTH OF TIME for immobilization of fractures in children is commonly accepted as less than necessary for fractures in adults[1] but little data are available on rates of healing. It is routine for patients referred to our office from emergency rooms to have been told that fracture immobilization will be necessary for six to eight weeks.

It has been assumed that, although fractures heal more rapidly in children than in adults, it is acceptable to immobilize pediatric fractures as long as desired by the physician.[2] This assumption is based on the popular notion[1] that stiffness in joints of children is unheard of. Cases of prolonged stiffness have occurred, however. For example, we recently observed a child with 50 degrees of restricted elbow motion one year after six-week immobilization for an undisplaced supracondylar fracture of the humerus. Further, there is unquestionably some morbidity and increased cost associated with unnecessary prolonged immobilization.

It was the purpose of this study to see exactly how long certain pediatric fractures were immobilized and whether this period of immobilization was adequate.

From The Children's Hospital, 561 South 17th St., Columbus, Ohio.
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Submitted January 6, 1972.

The Author

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Materials and Methods

Two hundred and ninety patients out of a total of 491 consecutive patients under 15 years of

Table 1. Average Time of Immobilization of Fractures in 290 Patients

Location	Number of Cases		Days of Immobilization Time		Problems	
	Displaced	Undisplaced	Displaced	Undisplaced	Displaced	Undisplaced
Foot	2	15	8	16	0	2
Ankle	2	8	27	15	1	2
Tibia and fibula	9	22	26	26	3	2
Patella	0	2	0	14	0	0
Femur	15	2	35*	25	3	0
Hand	15	21	15	18†	0	5
Forearm	108	45	28	24	12	4
Elbow (including supracondylar)	8	9	17	18	2	1
Humerus	9	9	19	19	1	1

*Includes one pathologic fracture immobilized 70 days.
†Includes two fractured naviculars immobilized 67 and 90 days.

age, treated by the author between March 1967 and June 1970 were contacted by our secretary via telephone. The remainder of the patients could not be contacted on three attempts. Patients with open fractures were excluded as were patients with multiple fractures and patients with clavicle fractures.

In general, it was the patients' parents who were asked the following questions: How did your child do overall? Have there been any other fractures? Was any other treatment given? Can you remember how long it was before the part was completely normal? Is there any problem related to this area now?

Charts and x-ray films were reviewed and fractures were classified as displaced or undisplaced. Undisplaced fractures were those with minimal displacement which, in the opinion of the treating physician, did not require reduction. The length of time of immobilization was recorded. Except for femoral fractures, all fractures were treated from the onset in plaster. Femoral fractures received 90-90 traction[3] until the fracture was clinically solid. This period of time, averaging 17 days, was followed by a period of immobilization in a spica plaster. Total treatment time is that listed in Table 1.

Table 2. Nature of Problems After Fracture in Children

Location	Problem	No. of Cases
Foot	Ache during wet weather	2
Ankle	Pain occasionally	1
	Pain in wet weather	1
	Swollen foot	1
Tibia and fibula	Pain during damp weather	3
	Persistent angulation requiring osteotomy	1
	Tired feeling	1
Femur	Knee stiffness	1
	Limp	2
Hand	Occasional pain	2
	Calcium deposits	1
	Deformity	2
Forearm	Occasional pain	5
	Pain in damp weather	2
	Lump	3
	Hypoesthesia in fingers	3
	Stiffness of elbow	1
	Swelling of wrist	2
Elbow	Elbow larger and/or longer	2
	Angulation (supracondylar fracture)	1
Humerus	Lump	1
	Angulation	1

The major criterion for discontinuance of immobilization was clinical stability of the fracture without pain on firm but gentle manipulation. If the fracture was tender or mobile, a second course of plaster immobilization was administered. The times recorded in Table 1 are average total times, including all cast changes.

The radiologic criterion for discontinuance was the presence of subperiosteal new bone joining the fracture fragments. This feature was present invariably when fractures were clinically asymptomatic and stable.

With neither of these criteria was it assumed that the fracture was completely healed, since we know this healing takes months or even years to occur.

Results

Table 1 shows the average time of immobilization of various types of fractures. In no case was removal from plaster followed by refracture within two months, a period which certainly would have included that period for which immobilization might have been continued by the most cautious of clinicians.

No child had any general functional limitations. Three had fractures of the same extremity within five to seven months after removal of plaster. In one case, the fracture was in the same site. This same arm was fractured a third time

eights months after the second fracture. At present, the arm is clinically and radiologically intact.

No further treatment was required except for physical therapy for one resistant knee-flexion contracture after femur fracture and one tibial osteotomy for persistent angulation. This case involved a minimally displaced fracture 1 cm below the proximal tibial epiphysis in a 4-year-old boy. Fifteen degrees of valgus deformity remained unchanged until osteotomy two years later.

Parents could not remember accurately how long it was before the part was completely normal. It was the general impression that four to six weeks were needed for displaced fractures and slightly less for undisplaced fractures.

A number of problems were noted at the time of review, on the average 21 months after fracture. Most of these problems were minor, but a compilation is given in Table 2. It can be seen that fractures in children are by no means without any consequences.

Discussion

The average time for immobilization of a variety of children's fractures managed by a single clinician in private practice has been determined. There is no evidence from this study that discontinuance of immobilization was premature, at least for the most part. In fact, since fractures were uniformly stable at the time indicated and usually had not been checked sooner, the time of immobilization was almost certainly excessive in terms of the criteria of the study.

Conclusion

Admittedly a variety of factors can be applied to the decision to discontinue immobilization of a fracture. The data included here suggest, however, that most fractures of children's bones may be removed safely from plaster after three to four weeks.

Acknowledgment: The services of Miss Lindy Rollyson are appreciated.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

Four years ago, this 63-year-old lady was treated for a carcinoma of her left tonsil with radiation therapy. She recently developed a small lump in her neck below the angle of her mandible. This was removed six weeks ago, but her physician discarded the specimen. The wound failed to heal and developed into the ulcer pictured in Figure 1.

What is your diagnosis, and how may this be diagnosed and treated?

(See p. 958 of this issue for further information and discussion.)



Fig. 1. This ulcerative lesion developed after removal of small "lump" in her neck.

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Submitted February 28, 1972.

Unilateral Amastia

Report of Two Cases

Avinash S. Deshmukh, M.B.B.S., and Tim Healey, D.M.R.D.

CONGENITAL ABNORMALITIES of the breast are found in about 10 percent of individuals.[1] Much has been written about the commoner anomalies, which include asymmetrical, supernumerary, and large breasts. Much less common anomalies include amastia and hypoplasia, which may be found alone, in association with ill-development of the pectoralis major muscle, or of the thoracic cage, or occasionally with other congenital abnormalities. Bilateral amastia is more common than unilateral amastia, and amastia is more common on the left side than on the right.[2]

The mammary gland is developed from the milk ridge, and amastia has been attributed to complete absence of this. Known causes for this include irradiation,[3] submammary injections or infusions in childhood, abnormal position of the fetus into utero with pressure effects, which may be associated with oligoamnios and/or small uterine cavity.[4]

It has been pointed out that bilateral and unilateral amastia are transmitted by different genes.[4]

This communication presents a report of two cases of unilateral amastia, one of which is the more rarely found right-sided anomaly, in association with absence of the pectoralis major muscle.

Case Reports

Case 1. This was a 19-year-old girl, whose mother had noted the absence of the breast and nipple on the right side soon after birth.

The patient had been using a wad of cotton-wool since puberty on the right side. After marriage, the left breast became larger and the patient presented at the outpatient department for advice. There was no family history of the anomalies, of any treatment by injections, or of radiotherapy in childhood.

On examination, the right breast, including the nipple and the sternal head of pectoralis major muscle, was absent while the left breast was large and pendulous (Fig. 1). Other secondary sexual characters were well developed. No other physical abnormalities were noted. A radiograph of the chest revealed absence of the



Fig. 1. Right breast absent, including nipple and sternal head of pectoralis major muscle (case 1).

Submitted March 8, 1972.



FIG. 2. Asymmetry of breasts of 12-year-old girl (case 2).

breast shadow on the right but no other abnormality. This patient refused operative reconstruction and chose to use a foam-filled brassiere.

Case 2. This 12-year-old girl presented at the medical outpatient department because of asymmetry of the breasts (Fig. 2). She had not commenced menstruating yet. There was no family history of any abnormalities or of any treatment by injection or by irradiation in childhood.

Examination revealed absent breast tissue on the left side, although the nipple and the areola were present. The right breast was well developed. Of the secondary sexual characters, only pubic hair growth was present. No other physical abnormalities were noted.

A radiograph revealed an absent breast shadow on the left side but no other abnormality.

It was decided that no treatment was indicated at this age.

Acknowledgment: The authors wish to thank Mr. F. Masina and Dr. E. W. Skipper for granting permission to publish the report of these cases.

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INFILTRATING BREAST CARCINOMAS in which recurrence takes place ten years or more after operation are reported to contain tumor cells of characteristic morphology. The cytological features of these tumor cells form the basis of the system of classification described here. Three cytological types are recognized, prognosis being best in type III. Typing is carried out on specimens stained with hematoxylin and eosin. The results of typing were reproducible in over 90 percent of cases and independent of the histology of the lesion. Correlation to survival time was shown in a total of 222 cases.—F. Hartveit, M.D., Bergen, Norway: *British Medical Journal,* 4:253-257, Oct. 30, 1971.

Liposarcoma of the Lower Extremity

A Review of 30 Cases from The Ohio State University Hospitals from 1955 to 1970*

Guillermo E. Quinonez, M.D.

SOFT TISSUE NEOPLASMS are diagnostic and therapeutic problems. Diagnostic difficulties arise primarily because of the similarities of the entire group of soft tissue tumors. Second, sarcomas in general may exhibit multipotentiality with the production of more than one cell type within any given neoplasm. However, despite their morphologic and microscopic resemblance there is considerable difference in behavior. Not only may benign and malignant tumors be confused but also differentiated and poorly differentiated lesions within any one category. This diagnostic dilemma has therapeutic overtones in that the failures of treatment of soft tissue neoplasms in general are: (1) local recurrence, probably secondary to inadequate primary excision and, (2) late metastases.

Liposarcoma among all soft tissue tumors occupies the most prominent place because of its frequency and potential behavior. Liposarcoma has been studied in detail much akin to the osteosarcoma.[1-3] Accumulative results have been applied to the grading system for liposarcoma (Enterline) which was devised to correlate with potential behavior.

Liposarcomas are frequently found in the lower extremities, and in fact are the most common soft tissue malignant tumors in that site. As a group they are probably the least understood and most inadequately treated of all malignant soft tissue neoplasms.[4] The review we have undertaken includes all liposarcomas and other malignant soft tissue tumors of the lower extremities, and in addition, a comparative relationship to bone tumors of the same areas. Cases have been derived from the medical records of The Ohio State University Hospitals, and in essence, this constitutes a 16-year experience with this neoplasm in this institution.

The Author

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Material and Methods

One hundred and sixty-two primary malignant neoplasms of soft tissues and bone of the lower extremity have been seen at The Ohio State University Hospitals during the years 1955 to 1970.

The cases were reviewed and the following parameters included in the study: age, sex, anatomic distribution, history, in particular the presenting symptoms, the location of the neoplasm, relationship to trauma, and diagnostic procedures including biopsy, physical examination, and x-ray. The study also included the study of the initial and subsequent therapy and a follow-up on each. Death was certified by use of the file of The Ohio State University Hospitals Tumor Registry, and those patients alive with or without disease have been seen on an annual basis since their initial therapy.

Tumors included as malignant soft tissue tumors are those included by Stout in his classic

*A portion of the thesis presented by the author in partial fulfillment of the requirements for the degree of master of science.

Submitted December 7, 1971.

fascicle;[4] the histologic grading systems used for liposarcomas were those proposed by Enterline, et al[5] in 1960. Neoplasms of bone which were used as a comparison were classified using the system of Dahlin;[6] plasmocytomas and other malignant tumors of the bone marrow space were not included in this study.

Results

Fifty soft-tissue malignant neoplasms of the lower extremity were found of which 30 were liposarcoma (Table 1). The age distribution for liposarcoma extended from the fourth to the eighth decade; the mean was 52.5 years. There was no sex predilection; 29 cases were white and one was a Negro (Table 2).

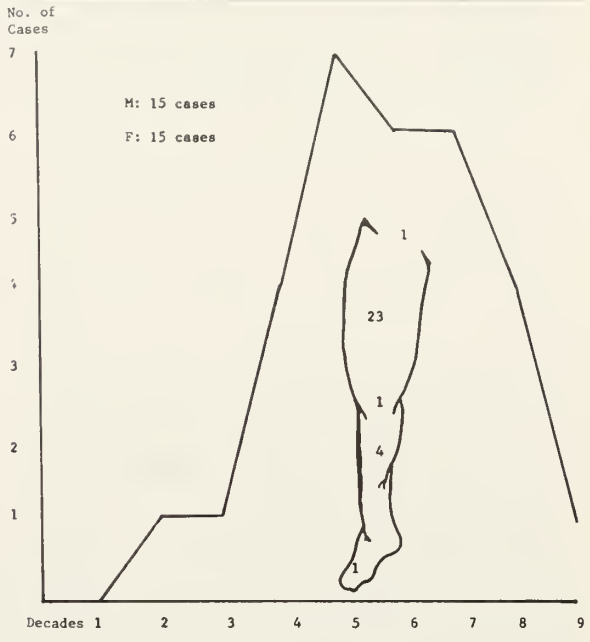
The major complaint on admission was a mass in the leg or thigh; only six patients complained of pain. No history of trauma was elicited in any case; nor was there a family history of malignancy in any of the patients. The duration of symptoms varied from one month to three years. Clinical examination showed that in 11 cases the tumor was less than 15 cm in diameter. In only two cases was it larger than 15 cm and in one case the tumor was described as poorly circumscribed. The initial clinical diagnosis in 25 of 30 cases was liposarcoma. There were only eight cases on record of any significant radiographic findings.

The first diagnostic procedure done on 20 of the 30 cases was incisional biopsy; needle biopsy was done in only two cases. In the remaining eight cases, tissue was not resected for biopsy at The Ohio State University Hospitals as they were referred with previous histologic material. One

Table 1. Classification of 82 Cases of Malignant Soft Tissue and Bone Tumors of the Lower Extremity

	No. of Cases
Soft Tissue Tumors	
Liposarcoma	30
Rhabdomyosarcoma	6
Fibrosarcoma	4
Neurofibrosarcoma	3
Synovial sarcoma	2
Kaposi's sarcoma	1
Malignant mesenchymoma	4
Total	50
Bone Tumors	
Osteogenic sarcoma	17
Malignant giant cell tumor	3
Ewing's sarcoma	3
Reticulum cell sarcoma	3
Chondrosarcoma	3
Adamantinoma	1
Malignant hemangiopericytoma	1
Fibrosarcoma	1
Total	32
Total Cases	82

Table 2. Age, Sex, and Topographic Distribution of 30 Cases of Liposarcoma of Lower Extremity



third of the patients seen were Group I of Enterline's classification (myxoid liposarcoma). No examples of Group II were seen. One third of the group of patients fell into Group V (pleomorphic liposarcoma) and the other ten patients fell into the third and fourth type (Table 3).

No correlation was found between local recurrence and metastases in Group I (myxoid liposarcoma). Local recurrence was the most common event for Group I (myxoid liposarcoma), although longer survival times were found in this group, seven out of ten patients survived 14 years beyond the last resection. Two of these seven cases had regional lymph node metastases at some time in the evolution of the disease. Three patients later showed metastases to the lungs. The lung metastases occurred 1, 3, and 11 years after primary resection of the sarcoma. All three of these patients died of disease. Pleomorphic liposarcoma (Grade V) also showed a high incidence of

Table 3. Distribution of 30 Cases of Liposarcoma of the Lower Extremity by Histologic Group (Enterline)

	No. of Cases
Myxoid (Group I)	10
Poorly differentiated myxoid (Group II)	0
Lipoma-like (Group III)	5
Myxoid-mixed (Group IV)	5
Nonmyxoid (Group V)	10
Total	30

Table 4. Modality of Treatment of 30 Cases of Liposarcoma of the Lower Extremity

Histologic Grade (Enterline)	Treatment							
	Local Excision	Local Excision + Radiation	Local Excision Followed by Amputation	Amputation	Chemotherapy	Radiation	Local Excision + Radiation + Chemotherapy	Local Excision + Radiation + Amputation + Chemotherapy
I	6	2	1	0	1	0	0	0
III	1	2	0	0	0	1	1	0
IV	0	0	1	3	0	0	0	1
V	1	4	0	2	0	0	3	0
Total	8	8	2	5	1	1	4	1

local recurrence but only three of ten patients are living free of disease 4, 6, and 11 years after resection. Five of the 11 patients demonstrated lung metastases six years or less after the resection of the primary tumor. One patient died as a result of surgery (pulmonary embolism).

The intermediate groups (Types III and IV) showed behavior ranging between the extremes of the myxoid and pleomorphic liposarcoma (Table 6). Lymph node metastases were confined to Types I, III, and V tumors (Table 7).

Treatment was not related to the histologic type of liposarcoma as far as we could determine. Eight of the 30 cases were treated with local excisions (15 of the lesions were locally excised with further treatment in particular lymph node dissection). Subsequent amputation, radiation, or chemotherapy also followed excisional biopsy or initial excisional therapy. Two of the cases were treated with radiation and/or chemotherapy and five were treated with amputation alone (Table 4). Of the total of seven patients on whom amputation was performed, two died of liposarcoma and two of unrelated disease. Three are alive 3, 4, and 11 years after amputation.

Discussion

The treatment and prognosis in liposarcoma varies considerably depending upon the grade and initial stage of the disease. At least half of the patients seen here had a previous primary procedure and, therefore, 50 percent of our cases were treated for a recurrent neoplasm. The initial inadequate excision confuses the subsequent biologic course, particularly as it relates to the probability of recurrence.

The recognition of malignant tumors of soft tissue was originally described by Virchow in 1856. He described fascial sarcoma of fibromatous or fibrosarcomatous origin, and introduced the term intramuscular myxosarcoma as a separate entity. He noted the presence of fat cells and considered it fatty degeneration in these neoplasms. Later authors confused intermuscular myxosarcoma with the true fascial sarcoma described by Virchow.[7] He also first described a tumor arising

Table 5. Criteria for Comparison Between Stout's and Enterline's Classification of Liposarcomas

Stout (1944)		Enterline (1960)	
Type 1	**Well Differentiated Myxoid Type** Predominant cell type resembled embryonal fat.	Group I	**Well Differentiated Myxoid Type** Predominant cell type resembled embryonal fat.
Type 2	**Poorly Differentiated Myxoid Type** Similar to first type but in which lipoblasts are bizarre and often monstrous. Fibrosarcomatous areas sometimes noted.	Group II	**Poorly Differentiated Myxoid** Similar to Stout's Type 2 except myxoid tumors containing fibrosarc-like areas or round-cells are assigned to Group IV.
		Group III	**Lipoma-like** Tumors remarkable for extent of adult fat formation.
Type 3	**Round Cell or Adenoid-type Cells** This cell is equivalent to the hibernoma fat cell.	Group V	**Nonmyxoid Type** This group is close to lipoblastic or round cell type of Stout, but is based on complete absence of myxoid elements.
Type 4	**Mixed Groups** Tumors composed of two or more elements of the preceding types.	Group IV	**Myxoid Mixed** Tumors predominantly myxoid but contained mixture of other types of cells, including round cells.

from adipose tissue.[8] Other papers have been published by Robertson; in 1916, he collected 51 cases from the literature dating back to 1873. Geschickter reported 13 cases in 1934. However, it was not until Ewing's publication in 1935 that the misconception concerning the classification of liposarcomas started to be clarified. Ewing called attention to the fatty tissue origin of the so-called intramuscular myxosarcoma. He also initially classified liposarcomas into two separate groups, those originating from adult fat and those originating from embryonal fat.[7]

One reason for the confusion of the origin of liposarcoma is unquestionably centered about the embryology of fat tissue in general. Lipid cells originally were thought to be modified fibroblasts.[1] It was not until the studies of Well,[9] and Murray and Stout[1] that this problem was resolved. Using tissue culture these investigators pointed out that actively growing lipoblasts, although superficially resembling fibroblasts, can be separated on the grounds of nuclear and cytoplasmic properties. Vellios,[3] in 1958, pointed out the origin of the lipoblasts in perivascular mesenchymal tissue. He also noted the first type adipose tissue to appear is the mixed variety and therefore is embryonal. The site of the hibernoma or brown fat of the hybernating animals was noted by Vellios also to occur in the axilla, mediastinum, and the peritoneal space of the human fetus (last trimester).[3] Neoplasms arising or related to this fat have been described by others. Scarpelli, using electron microscope and histochemical technics, supported the origin of the cells of the liposarcoma from the undifferentiated mesenchymal origin.[2] Similar studies concluded that liposarcomas originated from the intramuscular lining space and that cells in this area retain their potential for lipogenesis.[5] Ewing, interestingly enough, suggested this hypothesis 35 years before.[7] The original confusion concerning the morphology of the liposarcomas led to several investigators questioning the invasive capabilities of liposarcomas in general.[10] The publications of Ewing,[7] and Stout signaled the beginning of a reasonable approach to the classification of liposarcomas. Stout,[11] in 1944, proposed initial classification of liposarcomas based on tissue culture technics, that led him to describe an embryonal fat cell and hibernoma fat cell, based on the morphologic resemblance of these cells to the tumor cells in question. Although Stout's classification was based upon embryonal considerations it did not correlate well enough with the clinical behavior. In 1960, Enterline proposed his modification of Stout's classification,[5] his purported purpose being to correlate this histologic typing and biologic behavior (Table 5). Similar classifications have been proposed by Enzinger[12] and Reszel.[8]

The tumor in general is rare. Stout collected

TABLE 6. Relationship Between Histologic Group (Enterline) and Survival of 30 Cases of Liposarcoma of Lower Extremity

HISTOLOGIC GROUP (ENTERLINE)	SURVIVAL (IN YEARS)													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
I	○		○			●	●	●		●	◉	●		●
III	○		○	◉							●		◉	
IV	◣			●			◎				●			
V	◣ ○	○	◣	●		◎					●			
TOTAL	7	2	3	3		3	2	1		1	5	1	1	1

● Alive without disease
○ Alive with disease
◉ Dead without disease
◣ Dead with disease

41 cases in 37 years.[4] Pack and Pierson, associated with Memorial Hospital in New York, reported 105 cases in 25 years.[13] Enterline found 53 cases in 17 years at The University of Pennsylvania,[5] and Enzinger reported 49 tumors of the lower extremities and 44 tumors of the retroperitoneum in a 25-year period from the Armed Forces Institute of Pathology.[12] Reszel, et al reported on a review of 222 cases in the extremities and limb girdles from the files of the Mayo Clinic. This extended over a 55-year study.[8] In our study, we found 30 cases of liposarcoma of the lower extremity in a 16-year period.

In the various reported studies, there is a slight preponderance of males. The mean age in the present study is 52.5 years with a range of 16 to 81 years. Enterline[5] reported a mean of 53 years, Enzinger[12] and Reszel[8] a mean of 51 and 50.2 years respectively. It is noteworthy that in our Group I (myxoid liposarcoma) the mean age was 48.6 years, which differs, probably not significantly, from the 55.8 years reported for Group V. Liposarcomas in general are rare below the age of 30 years[14,15] and, in this particular study, only two of the 30 cases were patients less than 30 years of age. Overall, our small series differs little from the larger series reported. Presence of the mass, symptoms, and pain correlate well with previously reported groups. Relationship of trauma to the development of liposarcoma is controversial[16] and, in several cases, hematoma formation have been reported in the past.[5] We were unable to substantiate this relationship. Another controversial point is the malignant degeneration of lipomas or multiple lipomatous neoplasms to subsequent liposarcoma. A doubtful case of this is reported in the present series and, although questionable, it is added to those previously reported by Pack and Pierson[13] Stout,[11] and Wright.[17]

Liposarcomas have been described in all areas of the body where fat is present.[14] For example, they have been described in such diffuse areas as lactating breasts, bone marrow, spine,[18] liver,[19] mesentery, vulva, extradural space, mediastinum, pleural cavity,[10] etc. However, overall, the lower extremities are the most common site for liposarcomas.[20] Tumors of this area are characteristically deep within the facial planes and only rarely found in the subcutaneous position. In Pack's series,[13] tumors of the lower extremities represented 62.7 percent of the total number of cases. Stout,[11] Enterline,[5] and Enzinger[12] all showed a definite higher incidence of this tumor in the lower extremities than elsewhere. Reszel found 169 cases in the lower extremity and only 53 in the upper extremity.[8] Other authors have found liposarcoma to be primarily located in the popliteal space, followed secondly by the thigh.[12,15,21] In this series, as well as that of Enterline's[5] and others,[8,22] the thigh was the most common primary site. It also has been reported that the tumor most commonly occurs on the right side.

Liposarcomas in general have been described as being the largest of the soft tissue tumors and giant neoplasms have been reported by Virchow and Wells.[9] Due to the anatomic location and the tendency for early detection, the average diameter of the tumor in this study is less than 17 cm. No correlation between the size and histologic grade has been found. The huge tumors described

TABLE 7. Behavior Pattern of Liposarcoma of the Lower Extremity by Histologic Group (Enterline)

Histologic Group (Enterline)	No. of Local Recurrences								Site of Metastasis			
	None	1	2	3	4	5	6	7	8	Reg. Lymph Nodes	Lung	Other	None
I	4	1	1		2				2	2	3	1	5
III	3	1		1						1	1		3
IV	3	1	1								1		4
V	3	4	1			2				2	5	1	4

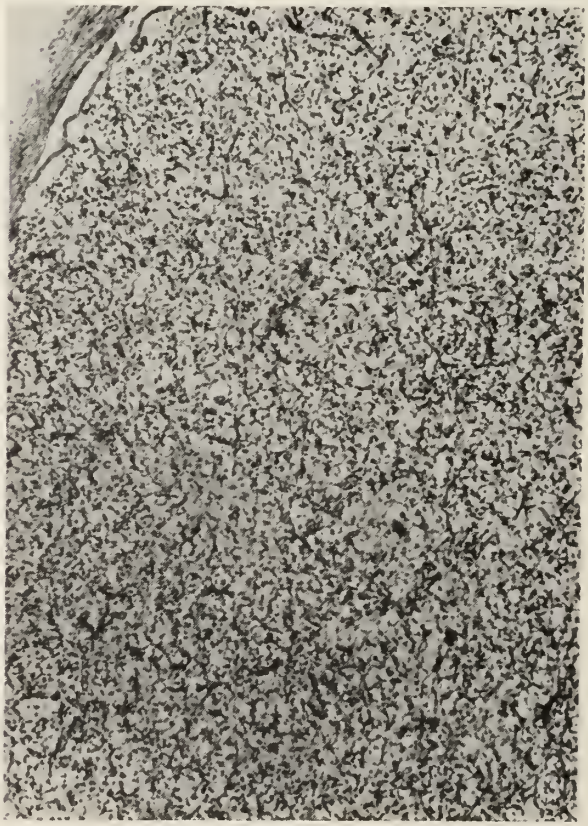


FIG. 1. Well differentiated myxoid liposarcoma (Group I). Photomicrograph of tumor showing capsule and uniform spindle-shaped cells with hyperchromatic nuclei. Clear cytoplasm is lipid.

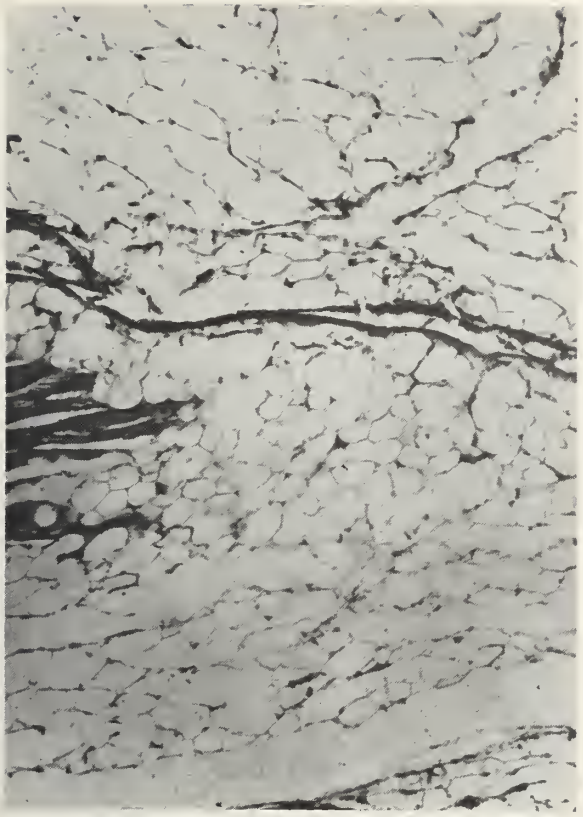


FIG. 2. Lipoma-like liposarcoma (Group III). Cells of tumor are well differentiated, but this neoplasm invaded neighboring tissues. These tumors are frequently mistaken for a benign "lipoma," but they are not.



FIG. 3. Myxoid-mixed liposarcoma (Group IV). Combined areas of myxoid plus fibrosarcomatous cells are shown. Tumor is extremely hyperchromatic. Such lesions have been mistaken for fibrosarcoma; fat stains help differentiate this type of liposarcoma.

in other series are usually liposarcomas of the retroperitoneal area.

Multifocal origin has been described for liposarcoma in the literature. Although reports have been difficult to interpret on the basis of the history,[21] no cases in this category were present in this study. We did not find any liposarcomas arising from underlying bone such as described previously by Pack and Pierson.[13]

In the present series, we present a clinical impression of liposarcoma made in 25 of 30 cases. The location, physical finding, size, rate of growth and local recurrence were helpful. However, this percentage includes the 17 patients who were referred here for secondary treatment. Clinically, one of the cases was erroneously thought to be osteosarcoma because of its fixation to underlying bone. The radiographic recordings were negative. In general, radiographic examination was used primarily to eliminate the possibility of an underlying primary bone tumor.

Excisional biopsy with frozen section was the procedure of choice in this series. Only two needle biopsies were performed. It is our opinion that open biopsy is the best method to obtain adequate tissue for the grading of this group of neoplasms. The incision must be planned so that the resultant surgical incision can be incorporated in the biopsy site.

Utilizing the classifications of Enterline, liposarcomas most frequently fell into Group I (myxoid liposarcoma). Based on the microscopic interpretation of the permanent sections, this was not noted in the present study (Table 3). Nevertheless, the tumors did tend to become more malignant histologically with recurrence.

The presence of mucoid material within the tumor has resulted in differential diagnostic problems with soft tissue myxoma or myxosarcoma. Enzinger[12] described the myxoid type by comparison with the embryonal fat as follows: "As in the primitive fat organ, the tumor is composed of three main elements: (1) proliferating lipoblasts in various stages of differentiation, (2) a delicate plexiform capillary pattern; and in between, (3) a myxoid matrix containing abundant hyaluronidase-sensitive acid mucopolysaccharides" (Fig 1). It has been shown that this mucoid substance is an essential intermediate stage in the formation of fetal fat. At least one of the cases in Group I in this series was found in a review of myxomas of soft tissue. Only a few mitotic figures were seen

and the inflammatory component was not striking. This trend is consistent with that in other series.[12]

No examples of Group II, the so-called poorly differentiated myxoid liposarcomas, were found.

In Group III tumors, that is lipoma-like tumors (Fig. 2), the difficulty was in differentiating liposarcomas from lipomas. The question of "malignant degeneration" may have arisen from this group of tumors. (1) Anatomical location can be helpful, lipomas have a subcutaneous origin. (2) Enterline noted: "We would think an acceptable case of liposarcoma arising secondary to a lipoma should meet the criteria of an encapsulated fatty tumor with obvious liposarcoma restricted to a portion of it, and with the remainder composed of completely mature lipocytes indistinguishable from normal fat."[5] Our case does not meet these criteria; however, the case reported by Sternberg[23] did. (3) The clinical behavior of the tumor. (4) Sex-lipoma is more frequent in females.[5,20] The tendency for lipomas to be multiple.[9]

Both Groups IV and V liposarcomas have been confused with pleomorphic fibrosarcomas, rhabdomyosarcoma, or malignant mesenchymal tumors, because the criteria used to place tumors in Group IV include the presence of either myxoid elements and/or fibrosarcomatous elements or round cells (Fig. 3). However, the tumor group which has created the greatest problem of diagnosis is that of Group V. This diagnosis is based on the interpretation of multiple samples, and only then when the lipomatous component is considered and dominant over the other tissue components, is the diagnosis of liposarcoma considered (Fig. 4).

The presence of other tissue patterns within Group V liposarcomas is due to the demonstrated multipotentiality of the tumor cells. This tumor is considered the most undifferentiated and the most aggressive of the five groups.

None of the five groups of tumors showed encapsulation, an important fact which has to be considered in therapy. Sometimes, recurrences can be predicted microscopically from the relationship of the margin of resection.

The higher grades of liposarcoma had an equally high incidence of local recurrence and, in addition, a higher frequency of distant metastases (lung). No difference in the metastatic pattern to regional nodes was found in the different groups (Table 7). In the M.D. Anderson series, 5 percent of the cases had microscopically proven lymph node metastases.[8] In our opinion, the presence of reactive changes in the regional lymph nodes in this particular study produced false negative clinical diagnosis in five of the 30 cases. The cases in Group V metastasized to lung as expected and, in several cases, lung metastases were present at the time of the initial visit. However, tumors

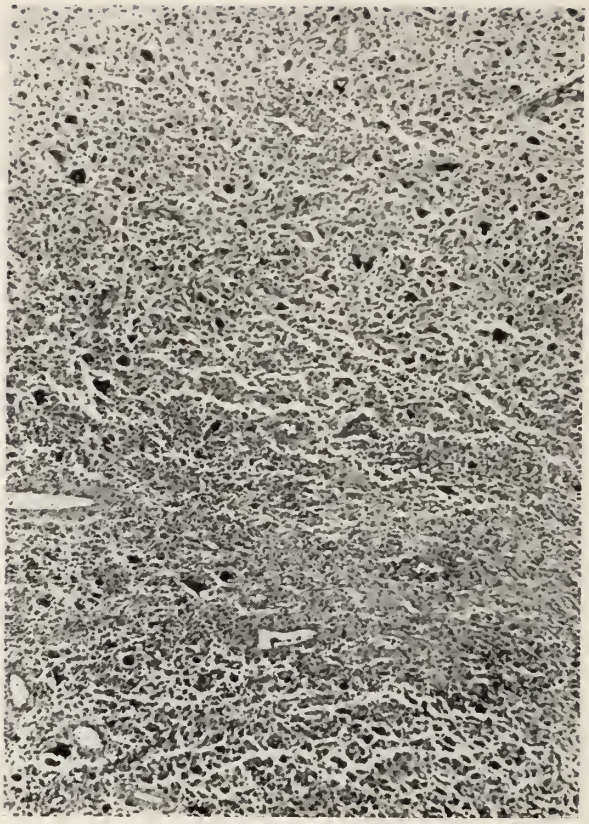


FIG. 4. Nonmyxoid liposarcoma—pleomorphic (Group V). Tumor is composed of round small cells with hyperchromatic nucleus, granular and well delineated cytoplasm. Other highly anaplastic cells are shown in same field. These are most malignant neoplasms of group.

from the other groups also demonstrated lung metastases but with a lower frequency (Tables 6 and 7). Shuman[24] reported metastases to the lung in from 5 to 40 percent of the cases depending on histologic type, and Reszel[8] showed 45.8 percent with pulmonary metastases. The results of our study included 33 percent with pulmonary metastases. Two unusual locations for metastases were noted, (1) to the umbilicus and (2) to the chest wall. In general, the intermediate groups showed an evolutionary behavior between Group I with its contaminate local recurrences and Group V with its highest incidence of lung metastases.

The difficulties in retrospective evaluation of treatment can be clearly seen. In 17 cases out of 30, one or more recurrence occurred regardless of the histologic group. Adequate radical surgical excision is the procedure of choice.[11] If the local excision is not successful in removing the tumor, a more aggressive procedure, such as amputation, can be performed. Chemotherapy and radiation therapy were used in this series usually in advanced cases; therefore, evaluation of these types of treatmen is difficult to offer. Some workers use radiotherapy prior to surgery to reduce the size of the

tumor.[25] This is more frequently accomplished in the cases of Group I (myxoid group) as a result of the tumor vascularity. Others have used radiotherapy alone with questionable results.[8,13]

Summary

One hundred sixty-two malignant neoplasms of soft tissue and bone of the lower extremities have been reviewed from the records of The Ohio State University Hospitals, between the years 1955 and 1970. One third of the tumors were liposarcomas. We have emphasized this occurrence, the histologic classification, and the prognosis as related to therapy as well as the behavior of this group of tumors.

Acknowledgement: I am deeply indebted to Dr. William Holliday, my advisor in the graduate school at The Ohio State University, for guidance in the preparation of this paper.

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SUDDEN DEATH IN HOSPITAL. — In a group of 339 patients with acute myocardial infarction treated in a coronary care unit, 273 left the unit while improving and were expected to leave hospital alive; 23 had a cardiac arrest or died suddenly while still in hospital—17 died immediately or after temporary resuscitation and six were resuscitated to leave hospital alive. Ventricular fibrillation was found in 13 of the 20 patients attended by the cardiac arrest team. The incidents were scattered from the 4th to the 24th day after the onset of infarction. Risk factors in these "late sudden death" patients were compared with the 250 patients who left the unit while improving and did not die or suffer cardiac arrest. The patients susceptible to late sudden death were characterized early in their hospital course by the findings of severe, predominantly anterior infarction, left ventricular failure, persistent sinus tachycardia, and frequent ventricular arrhythmias. It is suggested that such patients be chosen for prolonged observation in a second-stage coronoray care unit. — Peter Thompson, M.R.A.C.P., and Graeme Sloman, F.R.A.C.P., Victoria, Australia: *British Medical Journal*, 4:136-139, Oct. 16, 1971.

Dynamic Electrocardiography

A Study of Patients Recovering from Acute Myocardial Infarction

James B. Kuplic, M.D., and Myron H. Luria, M.D.

SINCE THE DEVELOPMENT of dynamic electrocardiography by Holter in 1961, a variety of applications have been described.[1] The technic has been used to investigate causes of palpitations,[2] to determine if cardiac arrhythmias are a cause of transient neurologic disorders,[3] to determine if implanted pacemakers are functioning,[4] and to evaluate changes in heart rhythm which occur in individuals under a variety of environmental conditions with or without heart disease.[5]

The present investigation introduces a new application for dynamic electrocardiography — an attempt to identify those patients at risk of sudden death, who are in the ambulatory phase of recovery from acute myocardial infarction, and are about to be discharged from the hospital.

Methods

An eight-hour dynamic electrocardiogram was recorded on patients recovering from acute myocardial infarction during their ambulatory phase prior to discharge from St. Luke's Hospital. Criteria for inclusion in the study group included a diagnosis of acute myocardial infarction based on history, serial electrocardiograms, and serial enzyme studies (creatine phosphokinase, serum glutamic oxaloacetic transaminase, and lactic dehydrogenase). In addition, each patient was in the ambulatory phase of recovery, usually the third or fourth week after the acute attack. A control group consisted of patients admitted to the hospital who were ambulatory and had no past history or electrocardiographic evidence of an old myocardial infarction.

Each patient was connected to a portable magnetic tape electrocardiographic recorder.* Bipolar lead electrodes were placed along the long axis of the heart resembling lead V_5 of the standard electrocardiogram. The patients continued in their daily activities, including eating, washing, observing television, using the bathroom, and walking several times a day in the hospital corridors. They were also instructed to record a diary of the events that transpired during the eight-hour study period.

The magnetically taped dynamic electrocardiogram was then scanned† through the use of two oscillosope screens. On one screen, successive PQRST complexes were rapidly superimposed on one another. On the other, the rhythm was presented in a picket-fence fashion, the height of each picket representing an R-R interval. By means

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*Model 350 Electrocardiocorder, Avionics Research Products Corp.

†Model 650 Electrocardioscanner, Avionics Research Products Corp.

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Table 1 — Frequency of Ventricular Ectopic Beats in Patients Recovering from Acute Myocardial Infarctions

Grade	No Medications	Digitalis	Quinidine	Digitalis+ Quinidine	Total Number of Patients
0	8	1	1	0	10
I	12	2	1	0	15
II	5	1	0	0	6
III	2	1	0	1	4
Total	27	5	2	1	35

of these two screens, any change in the shape of the PQRST complex or any change in the heart rate or rhythm could be detected. The tape was played back at 60 times the recorded speed so that the entire eight-hour tape record could be reviewed on the display screen in eight minutes. Selected rhythm strips were also recorded on paper at the usual 25 mm per second speed, when an arrhythmia was detected.

The patients were divided into four grades depending on the frequency with which ventricular ectopic beats were noted: grade 0 for no ventricular ectopic beats; grade I for ten or less ventricular ectopic beats per hour; grade II for 11 or more ventricular ectopic beats per hour; and grade III for multifocal ventricular ectopic beats.

Some of the patients were receiving medication which could enhance or suppress ventricular ectopic beats, and these were separated from the study group for comparison.

Results

The study group (Table 1) consisted of 35 patients whose average age was 60 years with an age range of 45 to 83 years. Twenty-seven of the 35 patients were not on digitalis or quinidine-like medications. Ten patients were without any ventricular ectopic beats, 15 patients had between one to ten ventricular ectopic beats per hour, six had 11 or more ventricular ectopic beats per hour, and four had multifocal ventricular ectopic beats.

Seventy-one percent of the patients (grade 0 plus grade I) had ten or less ventricular ectopic beats per hour, and 29 percent of the patients (grade II plus grade III) had 11 or more ventricular ectopic beats per hour or multifocal ventricular ectopic beats. If the patients on digitalis or quinidine preparations were excluded from the study, the percentage of distribution was not significantly altered, being 74 percent for grades 0 and I, and 26 percent for grades II and III.

The control group of ten patients (average age 59 years) had six patients in grade 0 and four patients in grade I, with no patients in grade II or grade III.

Patient Presentations

Patient 1 was a 59-year-old man who entered St. Luke's Hospital with an acute anterolateral myocardial infarction. During his acute-phase monitoring in the cardiac care unit, no ventricular ectopic beats were noted. The first ventricular ectopic beats noted were seen on a random electrocardiogram three days before his dynamic electrocardiogram, but none was noted on physical examination. The dynamic electrocardiographic tracing showed ventricular ectopic beats occurring 350 to 500 times per hour, with one episode of trigeminal rhythm lasting one minute during the evening supper period (Fig. 1). The patient remained asymptomatic and was to be discharged the next day, but he died suddenly that night.

Patient 2 is a 56-year-old man who was admitted with acute inferior myocardial infarction. During his continuous monitoring in the cardiac care unit, no ventricular ectopic beats were noted. Three weeks later, at the time of his dynamic electrocardiographic tracing, he was noted to have 15 to 25 ventricular ectopic beats per hour and one episode of accelerated idioventricular rhythm (Fig. 2). The patient was started on procaine amide and was discharged. He has been followed for the past six months in our outpatient clinic and has been asymptomatic without ventricular ectopic beats.

Discussion

Sudden deaths attributed to arteriosclerotic heart disease are the single most important cause of death in the adult population aged 40 to 64 years in the United States.[6] A recent study of sudden death in Baltimore (1964 to 1965) has disclosed that 61.4 percent of all sudden deaths were due to arteriosclerotic heart disease and that 60.2 percent of all deaths due to arteriosclerotic heart disease in the above age group were sudden and unexpected.[7]

In the Tecumseh study of the relationship of ventricular ectopic beats to coronary heart disease and sudden death, 158 per 1000 of those individuals with ventricular ectopic beats had manifest coronary artery disease as compared to 50 per 1000 in individuals without ventricular ectopic beats.[8] During the six-year study, individuals with antecedent ventricular ectopic beats died at a rate of 61 per 1000 as compared to 10 per 1000 for those without ventricular ectopic beats. The increased prevalence of coronary heart disease and incidence of sudden death in persons with antecedent ventricular ectopic beats were independent of several known coronary risk factors, ie, blood

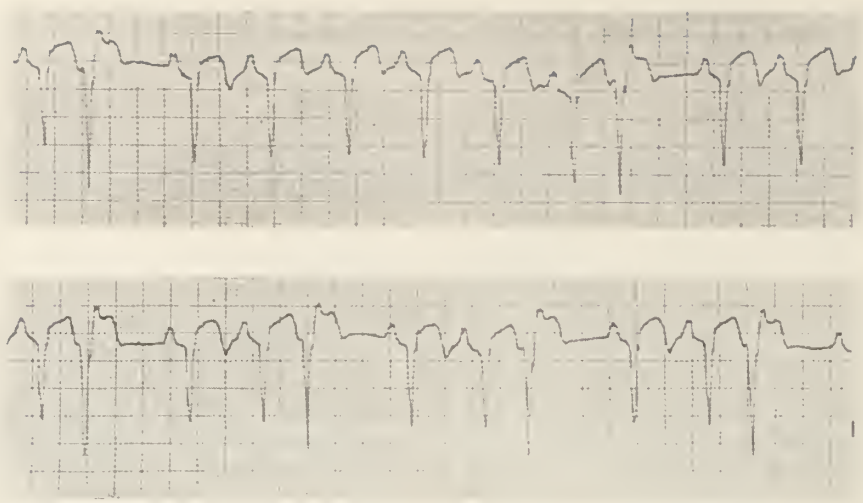


FIG. 1. Dynamic electrocardiogram in patient 1 showing frequent ventricular ectopic beats while both resting in bed (top) and eating supper (bottom).

pressure, cholesterol, relative weight, glucose tolerance, and smoking habits.

Hinkle, et al,[9] using dynamic electrocardiographic technics, studied a group of 301 asymptomatic, actively employed American men for six hours during a period of normal activity in order to determine the frequency of asymptomatic disturbances of rhythm. Ventricular ectopic beats were found in 62.2 percent of those studied and 8.8 percent exhibited more than ten ventricular ectopic beats per 1000 recorded beats. The number of deaths attributable to coronary artery disease that occurred among men who had ventricular ectopic beats was significantly greater than expected, especially in the group with more than ten ventricular ectopic beats per 1000 recorded beats. Moss, Schnitzler, and Green[10] have also recently reported a similar frequency of ventricular ectopic beats per 1000 recorded beats in patients three weeks after acute myocardial infarction. This latter system of calculating the number of ventricular ectopic beats per 1000 recorded beats was not used in the present study because it was less adaptable to the present recording system and thus less accurate. However, when the average heart rate for each patient in the present study was estimated, 11 percent of the patients had more than ten ventricular ectopic beats per 1000 re-

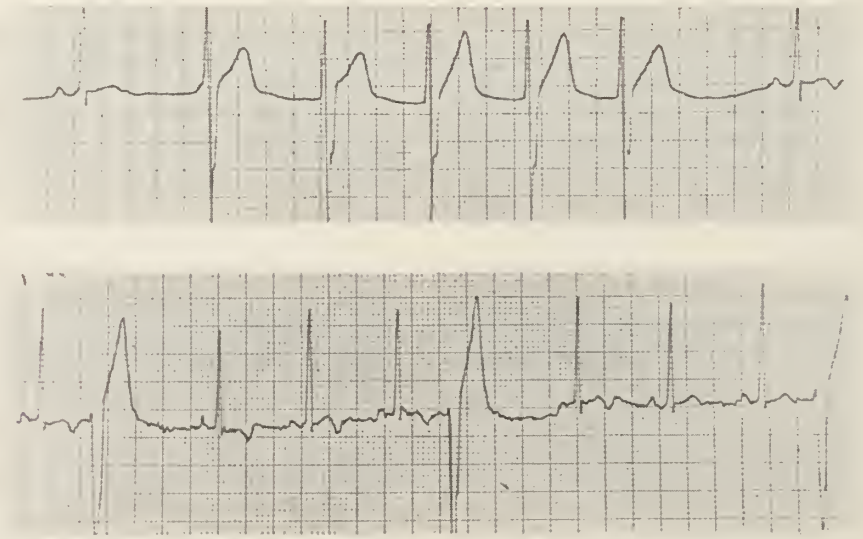


FIG. 2. Dynamic electrocardiogram in patient 2 showing accelerated idioventricular rhythm while sitting in bed (top) and frequent ventricular ectopic beats while eating dinner (bottom).

corded beats. Alternatively, Kotler and Tabatznik,[11] using methods similar to the present study, have recently assessed the number of ventricular ectopic beats per hour with dynamic electrocardiography in outpatients involved in a coronary drug project. The percentage of deaths was significantly elevated when 11 or more ventricular ectopic beats per hour (grade 2) or when multifocal ventricular ectopic beats (grade 3) were initially found prior to an average 30-month follow-up period.

A review of previous studies thus indicates that patients with coronary artery disease and frequent ventricular ectopic beats are at a great risk of sudden death. The results of the present study, therefore, have special significance. Twenty-nine percent of patients in the ambulatory phase of recovery after acute myocardial infarction had frequent ventricular ectopic beats prior to discharge. Indeed, one of these patients died suddenly before the recorded electrocardiogram could be evaluated. Most importantly, a specific group of patients, who are at risk, has been identified through the use of dynamic electrocardiography. Whether or not this specific group of patients will respond to antiarrhythmic therapy is unknown at present.[12,13] However, as more effective prophylactic antiarrhythmic agents become available, evaluation of patients by means of dynamic electrocardiography after myocardial infarction may be of assistance in delineating this important additional risk factor of coronary artery disease and sudden death.

Summary

An eight-hour dynamic electrocardiogram was obtained in 35 patients recovering from acute myocardial infarction during their ambulatory stage prior to hospital discharge. Eleven or more ventricular ectopic beats per hour or multifocal ventricular ectopic beats were found in 29 percent of the patients. The data indicate that evaluation of such patients for the occurrence of ventricular ectopic beats with dynamic electrocardiography may be a useful adjunct in delineating an important additional risk factor of coronary artery disease and sudden death.

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GALLBLADDER HAIKU

The venomous spirits of
Mind and body
Accrete
To painful extirpation

Paul R. Miller, M.D.
Columbus

Ruptured Abdominal Aortic Aneurysm with Aorta-Caval Fistula

Report of a Case

George Padanilam, M.D., and James F. Gorman, M.D.

IN TIME, the majority of patients with arteriosclerotic aneurysms of the abdominal aorta will develop complications, the most lethal being rupture. Although perforation most commonly occurs into the retroperitoneal space or peritoneal cavity, a few rupture into the gastrointestinal tract and rarely into the inferior vena cava or iliac veins. This latter phenomen produces a large arteriovenous fistula with serious local and systemic consequences.

Originally described over a century ago,[1] the first successful repair of an aorta-caval fistula was not accomplished until 1954. In a comprehensive review of the world literature, Nennhaus and Javid[2] discussed 30 reported cases of aorta-caval fistula, illustrating its comparative rarity. Recently, we encountered a patient who, in addition to having a spontaneous aorta-caval fistula, also had separate perforation of his aneurysm into the peritoneal cavity, the combination of which is extremely unusual and merits recording.

Case Report

A 62-year-old white man with known hypertensive cardiovascular disease and chronic pyelonephritis was admitted to the medical service at the Hospital of the Medical College of Ohio at Toledo, on January 5, 1971, with a two-day history of abdominal pain, vomiting, and dehydration. In 1965, he sustained left hemiparesis with a moderate neurologic residual. In December 1970, the patient was admitted to another hospital where an abdominal aortic aneurysm was discovered and confirmed by aortography (Fig. 1). However, both the patient and his family refused resection of the aneurysm at that time.

Initial examination revealed a dehydrated, chronically ill man with left hemiparesis. His blood pressure was 180/130 mm Hg, pulse rate 120 beats per minute, and temperature 99 F (37.2 C). A 12 X 7 cm, slightly tender, pulsatile mass was palpable in the abdomen. Minimal bilateral pedal edema was noted. Admission laboratory studies disclosed hemoglobin level of 10.4 gm per 100 ml, hematocrit reading 32 percent, and blood urea nitrogen (BUN) level of 40 mg per 100 ml. During the ensuing five days, the patient continued to complain of abdominal pain, nausea, and vomiting and was treated with intravenous fluids to correct the apparent dehydration. On the morning of the sixth hospital day, the abdominal pain became severe, and the patient was noted to be hypotensive with a blood pressure of 70/20 mm Hg. In addition, sudden and massive edema of the lower extremities and marked confusion became apparent. Examination of the abdomen at this time revealed diffuse tenderness and a to-and-fro bruit overlying the pulsating abdominal mass. A diagnosis of spontaneous aorta-caval fistula was entertained, and after initial resuscitation, the patient was immediately taken to surgery. Exploration of the abdomen revealed ap-

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proximately 1500 cc of fresh blood in the peritoneal cavity and a 2-cm free perforation of the abdominal aortic aneurysm on the left lateral wall sealed over with a fresh clot. In addition to this, a strong machinery-like thrill was palpable on the right anterior portion of the abdominal aortic aneurysm. Following application of vascular clamps above and below the aneurysm, the latter was quickly opened, revealing a 2-cm perforation into the vena cava, which was closed from within the aneurysmal sac. The remaining portion of the aneurysm was then resected and continuity re-established with an 18-mm dacron tube graft.

In the immediate postoperative period, the patient's blood pressure stabilized at 160/90 mm Hg; the patient became alert with an excellent urinary output. He continued to improve. However, by the tenth postoperative day, his urinary output gradually decreased. His BUN level at this time had risen to 128 mg per 100 ml and creatinine to 4.2 mg per 100 ml. By the 20th postoperative day, the patient became anoretic with rising BUN and creatinine levels. He continued this gradual downhill course and died on the 29th postoperative day.

Note

Chronologically, it would appear that rupture into the peritoneal cavity preceded development of the aorta-caval fistula. Despite marked initial improvement after surgery, our patient eventually succumbed to his preexisting pyelonephritis. No doubt, the preoperative reduction in effective renal blood flow associated with the massive arteriovenous shunting contributed to his renal failure.

Discussion

In contrast to traumatic aorta-caval fistulae, which commonly are well tolerated for months or even years,[3] caval fistulae associated with rupture of an abdominal aortic aneurysm are uniformly fatal, the longest reported survivor living six months with nonoperative treatment.[4] This difference in prognosis presumably reflects arteriosclerotic involvement of the coronary, cerebral, and renal arteries in a patient with an aortic aneurysm who poorly tolerates the effects of arteriovenous shunting with resultant diastolic hypotension.

The symptoms and physical findings of spontaneous aorta-caval fistulae are rather typical and have been described in detail.[5-7] Briefly, a patient with a known aortic aneurysm presents with the acute onset of low back or flank pain, edema, and venous distention of the lower limbs, varying degrees of confusion, and cardiac decompensation, depending on the size and rapidity of fistula development. On examination, the individual is usually hypotensive with a disproportionate decrease in diastolic blood pressure. Unless the patient is obese, a pulsating mass is palpable in the midabdomen. Auscultation reveals a typical to-and-fro murmur overlying the mass, which on occasions may only be detected during systole. If the fistula has been established for a sufficient length of time, striking venous distention of the legs and abdomen can occur often with visible venous pulsations. Resultant venous hypertension can induce exsanguinating rectal and genitourinary hemorrhage. Unless simultaneous intra- or retroperitoneal rupture has taken place, the hemoglobin and hematocrit values will be within the normal range. The blood urea nitrogen and circulating blood volume will generally be elevated if the fistula has been present for several or more hours. Frank cardiac decompensation of the high-output variety will eventually take place, but this is frequently a late and often preterminal occurrence. Treatment for spontaneous aorta-caval fistula is immediate resection of the aneurysm, replacement with an appropriate prosthesis, and closure of the fistulous opening in the vena cava. Preoperatively and during surgery, special care must be taken against overtransfusion because of the already expanded plasma volume.

Resection is accomplished by clamping above and below the rapidly opening aneurysm and controlling bleeding from the inferior vena cava by digital pressure. The fistulous site is then oversewn from within the aneurysmal sac. No attempt should be made to dissect the fistula site from without, as this usually results in catastrophic



Fig. 1. Transfemoral aortogram demonstrating large infrarenal abdominal aneurysm.

hemorrhage. In addition, cross-clamping of the vena cava will reduce cardiac output and adversely affect an already overburdened coronary circulation. After closure of the fistula, graft placement proceeds in the usual fashion.

Summary

A patient with a ruptured abdominal aortic aneurysm and a separate aorta-caval fistula has been presented. The sudden development of abdominal pain, massive lower extremity edema, and to-and-fro abdominal murmur in a patient with a known aortic aneurysm is pathognomonic of rupture into the vena cava and warrants immediate surgery to prevent irreversible alterations of cerebral, coronary, and renal blood flow.

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FOLLOW-UP CARE.—The course of 403 patients discharged consecutively from the medical service of a teaching hospital was studied to determine their medical care after hospitalization and to evaluate its effectiveness. Data were obtained from review of available charts and interviews six months after discharge of 341 of the 363 patients then alive. Of the 403 patients, 30 percent received medical care rated inadequate. Process data indicated frequent use of independent physician services without communication of hospital records. Outcome data indicated that 46 percent of the patients experienced decreased functional capacity. Forty patients had died; of those alive and interviewed, 27 percent experienced no change or an increase in symptoms, 37 percent experienced a decrease in ability to perform their major activity, and 30 percent had impaired ambulatory function. For 39 patients, decreased quality of outcome was judged to be due to inadequate medical care.

Evaluation of the quality of care received on a medical service providing short-term care is only possible if follow-up, end-result and outcome studies are combined with process data to supplement traditional methods such as mortality conferences and chart reviews. Failure to develop and use such methods in teaching institutions seems partly due to the training and attitudes of academic medical staffs. Emphasis has been placed on the house staff's ability to manage the acute in-hospital course of complicated or unusual diseases, not on the management of common diseases in an ambulatory setting. In such an environment a patient's medical care and health status after discharge cannot be best evaluated. A proper balance between these two aspects of medical education is needed since most internists are predominantly responsible for the long-term care of patients with common chronic diseases. Studies such as this could lead to a better understanding of the problems of managing patients with chronic conditions, to improvement in the training of house officers, and ultimately to a better quality of care.—Robert H. Brook, M.D.; Francis A. Appel, B.A.; Charles Avery, M.P.H.; et al, Baltimore: Special Article, *The New England Journal of Medicine,* 285:1509-1514, Dec. 30, 1971.

Urine Is Not Always Yellow

Leonard B. Berman, M.D.*

THE FAMILIAR COLOR OF URINE, may on occasion, dramatically depart from yellow to assume various shades of white, orange, green, red, brown, and black. This urinary rainbow contains a treasure of clinical clues to the physician who reads them correctly. For example, *milky white urine* may be the result of pus, phosphate crystals, or occasionally chyle. The first two can be separated by centrifugation and then identified microscopically. It may not even be necessary to do this if the urine pH is below 7.0, for phosphates will not precipitate in acid urine. Chyle is also associated with an alkaline urine, and is identified by its extractability with fat solvents. *Green urine* represents a mixture of blue and yellow. Therefore, a pseudomonas infection (blue pus) or ingestion of a methylene blue dye will combine with the normal yellow urochrome and emerge as green. The spectrum of *red, brown,* and *black* should be separated first into benzidine positive and benzidine negative. The former represents either red cells, free hemoglobin, or myoglobin. The red cells can be separated by centrifugation. Free hemoglobin is accompanied by red plasma while myoglobinuria is associated with a normally colored plasma. The urine containing red cells may be further interpreted. Glomerular bleeding (acute glomerulonephritis) has a number of distinct characteristics. For example, it is never associated with clots. Other types of bleeding from the kidney, eg, tumors and trauma, are frequently associated with clots and are almost always red rather than brown or black. The concentration of red cells or blood pigments also influences the color. For example, the massive hemolysis associated with falciparum malaria produces the black urine, whence the name black-water fever arises. The same group of colors, ie, red, brown, or black urine, *if benzidine negative* represents a diverse group of disorders, ranging from bile (brown) to melanin or homogentisic acid (black) to beet ingestion (reddish-brown) and others. The discoloration of the urine which occurs with beet ingestion is a genetically determined condition, unrelated to the amount of beets ingested. *Pyridium,* depending on pH, colors the urine red or orange. Thus with the naked eye, the centrifuge, and the microscope, we may revive the ancient and honorable art of water divining or as expressed in an earlier, less reticent age, pisse prophecy.

*Dr. Berman is Chief of the Department of Nephrology, Mt. Sinai Hospital of Cleveland.

Generic and Trade Name of Drug
Phenazopyridine HCl—Pyridium (Warner-Chilcott Laboratories)

Discussion of E.N.T. Case of the Month

(continued from p. 939)

The diagnosis is recurrent squamous cell carcinoma.

Any patient with the history of a head and neck tumor who develops a lump in the neck must be considered to have a lymph node metastasis until proven otherwise. This is true even if the "lump" appears many years after the primary site has been treated.

The diagnosis can be made by needle or excisional biopsy. *Histologic examination of all tissue removed is mandatory* so immediate therapy can be instituted. In this case, the six-week delay in diagnosis allowed the tumor to infiltrate the skin of her neck necessitating a more extensive surgical procedure.

Treatment consisted of a left radical neck dissection and excision of the skin of her neck (Fig. 2).

This left a large defect in a previously irradiated area. Since closure must be with non-irradiated tissue, a flap from her chest was elevated. This large medial-based chest flap receives its blood supply from the perforating branches of the internal mammary artery. The chest flap is rotated into place (Fig. 3) covering the neck defect. The bare deltoid and pectoralis muscles of her chest will be covered with a split-thickness skin graft.

Eighteen months after surgery the patient is free of disease. Note the acceptable cosmetic result of both her neck and shoulder (Fig. 4).

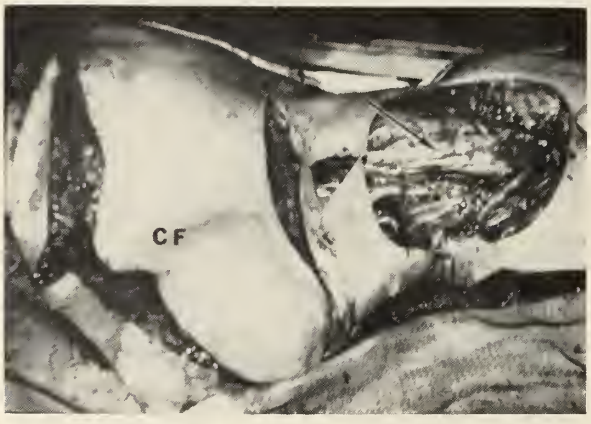


Fig. 2. Skin of neck has been excised and radical neck dissection done. Note medial-based chest flap (CF) which has been elevated. Arrow points to carotid artery.



Fig. 3. Chest flap is used to cover neck defect. Bare deltoid and pectoralis muscles of chest will be covered with split-thickness skin graft.



Fig. 4. Patient is free of disease two years after surgery.

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium®
(brand of triamterene) and 25 mg. of hydrochlorothiazide.

CAN STOP POTASSIUM DEPLETION BEFORE IT STARTS

WITH NO SACRIFICE OF THIAZIDE EFFECTIVENESS

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

***Indications:** Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. Also, mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Carolina, P.R. 00630
a subsidiary of Smith Kline & French Laboratories

IN EDEMA*—IN HYPERTENSION*

If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

e 25, tall, slender, athletic,
h flat chest. On a progestogen-
minant 50-mcg.-estrogen O.C.
s recurrent trichomoniasis
d Monilia.
Indicates estrogen deficiency and
cess of progestogen in current O.C.
1st choice: Switch to a com-
iation pill with 100 mcg.
rogen and less progestational
ivity (such as **Enovid-E**® or
ulen® or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.
Indicates probable need for more estrogen.
1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen**®).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.
Indicates probable progestogen excess.
1st choice: Switch to a center-spectrum pill (such as **Ovulen**®).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has pre-menstrual fluid retention and leg cramps.
Indicates probable excess of estrogen.
1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen**®).



Ovulen® a balanced center-spectrum O.C. for most
Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen® a moderately progestogen-dominant O.C. for many
Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

SEARLE Products of SEARLE & CO.
San Juan, Puerto Rico 00936

Enovid-E® a moderately estrogen-dominant O.C. for some
Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

SEARLE Product of Searle Laboratories Division
G.D. SEARLE & CO.
P.O. Box 5110, Chicago, Illinois 60680
Where "The Pill" Began

r a brief summary
prescribing information,
ease see next page.

a family of O.C. products to help you match the right pill to the right patient

Ovulen®

Each white tablet contains
ethynodiol diacetate 1 mg / mestranol 0.1 mg.

Demulen®

Each white tablet contains
ethynodiol diacetate 1 mg / ethinyl estradiol 50 mcg.

Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.

Actions – Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Ovulen and Demulen are indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. **4.** Sartwell, P. E., Masi, A. T., Arthes, F. G., Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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norethynodrel 2.5 mg / mestranol 0.1 mg

Actions – Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication – Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

Enovid-E®

brand of norethynodrel with mestranol

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Where "The Pill" Began

272R

AMA Clinical Convention

Cincinnati, November 26-29

THE Ohio State Medical Association and the Academy of Medicine of Cincinnati will host the American Medical Association for its Clinical Convention to be held in Cincinnati, November 26-29. As members in the host state, Ohio physicians may wish to make a special effort to turn out and welcome their colleagues from all parts of the country.

The AMA House of Delegates will meet on Sunday afternoon, November 26, and again on Wednesday afternoon, November 29.

An excellent scientific program is scheduled beginning on Monday. Scientific features will be in the form of morning postgraduate courses, luncheon roundtable discussions, and the scientific sessions.

Postgraduate courses on three mornings from 7:30 to 8:50 a.m. will include the subjects of blood gases, fluid and electrolyte balance, practical endocrinology, and principles of EKG interpretation.

Luncheon roundtables will include a variety of subjects of practical application in everyday practice. Mailings from the AMA will include details on subjects to be covered.

Scientific sessions begin on Monday at 10:00 a.m. with three concurrent sessions. Monday morning's subjects are cardiac arrhythmias, joint disease, and noninstitutional psychiatry.

On Monday afternoon the subjects will be cardiology, dermatology, and obstetrical problems.

Tuesday morning scientific sessions will begin at 9:00 a.m. and include pediatrics, disorders of the head and neck, and modern trends in gastroenterology.

Tuesday afternoon programs will include pediatric surgery, neurology and neurosurgery, and gastroenterologic problems.

Wednesday morning subjects are infectious disease, urologic disorders, and practical anesthesia.

Wednesday afternoon's scientific sessions will cover diabetes, old problems-new ideas, and the acutely injured patient.

The Scientific Exhibit is always a leading attraction at AMA Clinical Conventions, and this year's is expected to draw special attention. The special exhibit on fractures and another on resuscitation are expected to be centers of interest.

Extra attractions during the meeting will include tours of the Medical Laser Laboratory and the Shrine Burns Institute.

The Second National Open Hearing by the AMA's Council on Long Range Planning and Development is scheduled for Saturday, November 25, on the eve of the meeting.

The 14th National Conference on the Medical Aspects of Sports will be held on Sunday, November 26.

Also on Saturday, November 25 the Council on Medical Service is sponsoring a Conference on Home Health Care.

Another Saturday meeting is the second Business Meeting for all interested Interns and Residents.

The Woman's Auxiliary to the Cincinnati Academy is sponsoring a number of events in which doctors' wives will be especially interested. Also numerous events of interest to children and young people are scheduled, an added incentive for physicians to bring their families.

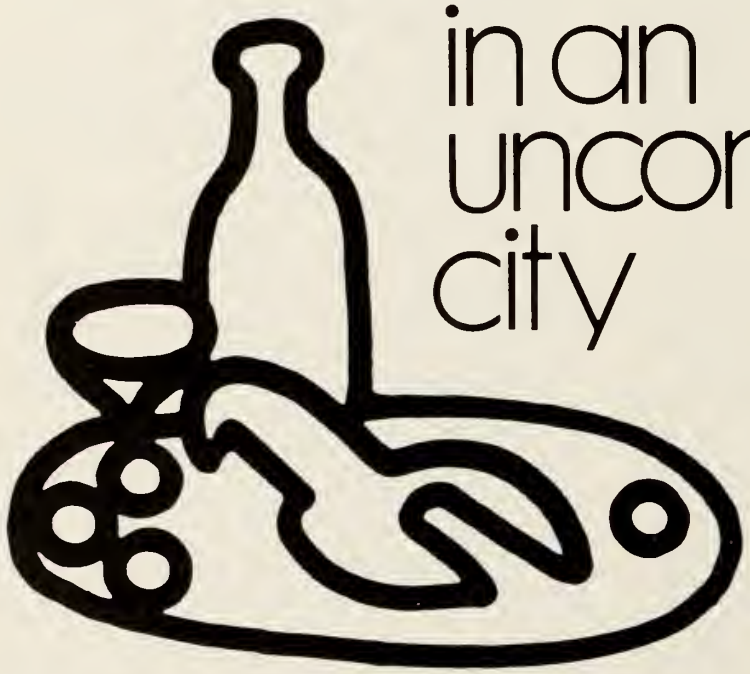
Special mailings as well as AMA publications will give fuller details on features of the meeting.

— Turn Page for More on AMA Convention —

The American Medical Association Is Coming to Ohio . . .

for the 26th Clinical Convention, Cincinnati, November 26-29

an exciting convention in an unconventional city



The Scientific Program — The door to a rich learning experience

Are you as up-to-date in your specialty as you'd like to be? Here's your chance to close the gap and gain continuing education credit besides. Begin with a 3-day total immersion course. Follow up with stimulating conferences, roundtable discussions, the latest medical films, and 250 scientific and industrial exhibits.

Surprising Cincinnati

It's golfing on a challenging course. Yes, *even* in November. It's joy in your youngster's eyes as you thrill to Emmett Kelly's Circus. It's the future melting into the past — skyscrapers amidst quaint homes, old world shops and art galleries. The restaurants? A word of caution: diet *before* you come. Cincinnati — a totally different kind of city. One the entire family can enjoy. Bring yours.

Educational Extras in and around Cincinnati

Dr. Albert Sabin researched the polio vaccine at Children's Hospital. The Medical Laser Laboratory pioneered in using lasers for surgery and dermatology. If you'd like to visit these — the Shriners Burns Institute — or any of the hospitals, labs and research facilities around Cincinnati, the AMA Information/ Entertainment Center will be happy to help you arrange it.

Outstanding Scientific Exhibits at 1972 Annual Meeting

HERE ARE ADDITIONAL descriptions and illustrations of outstanding exhibits at the 1972 OSMA Annual Meeting in Cincinnati, May 8-11, where the scientific, health education, and technical exhibits, as well as the art show, were major features of the convention.

Several exhibits were selected as outstanding by a judging committee and the sponsors were presented certificates of recognition and permanent type plaques to be displayed on respective exhibits and afterwards kept as mementos.

An article in the August issue of *The Journal,* beginning on page 806, featured some of the outstanding exhibits. A special feature on the Art Show began on page 891 of the September issue. An article in the Clinical and Scientific Section of the September issue elaborated on the Maternal Health exhibit. Please refer to article beginning on page 867 of that number.

Following is additional information on four of the outstanding exhibits.

Hip Arthroplasty Exhibit Wins Silver Award

The Silver Award in the teaching field went to the exhibit entitled "Indications for Total Hip Arthroplasty," sponsored by the Cleveland Clinic, Department of Orthopaedic Surgery: Charles H. Evarts, M.D., H. Royer Collins, M.D., Kenneth E. DeHaven, M.D., Carl I. Nelson, M.D., and Alan H. Wilde, M.D.

This exhibit was also shown at the American Medical Association Annual Convention in San Francisco, June 18-22, and was given a Certificate of Merit.

Following is a description of the exhibit and the procedure presented, as written by one of the sponsors.

The exhibit depicted the indications for the Charnley Mueller total hip replacement arthroplasty and a pictorial demonstration of the operative technique. The indications for the total hip arthroplasty have emerged through our experience now with over 1,000 Charnley Mueller total hip arthroplasties. We have reviewed the first 500 total hip replacements and the preoperative diagnosis was primary osteoarthritis in 54 percent of cases, secondary osteoarthritis in 26 percent, rheumatoid arthritis in 16 percent of cases, failed prosthetic replacement arthroplasty following fractures of the femoral neck in 4 percent.

The average age of the patient at the time of surgery was 65 years in those with osteoarthritis and 53 years in patients with rheumatoid arthritis. Patients were evaluated on an objective basis by use of the Iowa hip evaluation and the average preoperative Iowa hip score was 43 points out of a possible 100 points in patients with osteoarthritis and 36 points in those with rheumatoid arthritis. One hundred and five of the 500 cases had previous surgical treatment and this was 21 percent of the total series. Of these, 46 percent were failed endoprostheses, 36 percent failed cup arthroplasties, 12 percent failed osteotomies, 4 percent Girdlestone procedures, 1 percent arthrodeses, 1 percent failed bone grafts. The incidence of postoperative complications at the time of review were as follows: Nerve palsies either femoral or sciatic—1.8 percent, dislocation—1.2 percent, fracture of the shaft of the femur—0.8 percent, and infection—0.6 percent.

It is felt that the major indications for total hip replacement arthroplasty at the present time are: 1. Marked loss of bone substance of the acetabulum and femoral head. 2. Severe bilateral involvement of the hip joints. 3. Failed arthroplasty, cup or endoprosthesis. 4. Failed femoral osteotomy. 5. Other indications include failed arthrodesis, failed previous total hip replacement, failed Girdlestone procedure, and bone tumors of the proximal femur.

At the present time with our current experience of over 1,000 cases, we feel that the early results of the Charnley Mueller total hip replace-

ment arthroplasty have been consistently superior to other forms of surgical treatment of the hip. Long term studies are in progress to determine possible late complications and wear of the high density polyethylene plastic cup.



Dr. H. Royer Collins, left, one of the sponsors, here receives the Silver Award in the teaching field, for the exhibit, "Indications for Total Hip Arthroplasty." Making the presentation is Dr. P. John Robechek, 1971-1972 OSMA President.

Trigeminal Neuralgia Exhibit Given Honorable Mention

Honorable Mention went to the exhibit entitled, "Percutaneous Radiofrequency Coagulation of the Gasserian Ganglion for Trigeminal Neuralgia," sponsored by John M. Tew, Jr., M.D., and Frank H. Mayfield, M.D., Departments of Neurosurgery, Good Samaritan and The Christ Hospitals, Cincinnati.

Following is a summary of the procedure presented in the exhibit, as briefed by one of the sponsors.

During the past five years a new technique has come to the attention of medical practitioners interested in the treatment of trigeminal neuralgia (tic douloureaux). This procedure appears to provide a safe effective means for achieving long-standing relief of this dreaded condition. Although Tegretol and other related drugs have provided a gratifying addition to our medical treatment, it has been learned that many patients do not tolerate these drugs or fail to obtain satisfactory relief. It is the purpose of this exhibit to review the technique, physiological basis, and results obtained with this procedure in 75 patients.

The physiological basis of this technique lies in the premise that the pain of trigeminal neuralgia is conducted through the thinly myelinated fibers of the trigeminal nerve. It is known that these fibers are more sensitive to heat than those larger and more heavily myelinated fibers of the motor root and sensory nerve conducting touch reception. Therefore, an insulated needle is inserted into the trigeminal cistern among the rootlets of the trigeminal nerve; electrical stimulation permits precise localization in the desired area of the rootlets responsible for the painful phenomenon. With the correct frequency of stimulation and intensity we are frequently able to precisely reproduce the pain experienced during a paroxysm of tic douloureaux. Armed with this information and anatomical localization it has been possible to briefly anesthetize the patient with a short acting barbituate administered intravenously, and to create a radiofrequency heating lesion in the vicinity of the nerves responsible for the pain. The end result is analgesia; that is, complete loss of discrimination of



Honorable Mention went to the exhibit entitled "Percutaneous Radio Frequency Coagulation of the Gasserian Ganglion for Trigeminal Neuralgia." Here Dr. Jerry L. Hammon, left, member of the Committee on Scientific Work, discusses the exhibit with Alan McLaughlin, surgical technician, who helped man the booth.

pin prick in the area of the radiated pain, but preservation of touch and the muscle power necessary for mastication.

In our experience with more than 75 cases it has been possible to achieve relief of pain in 100 percent of the individuals. The recurrence rate of 8 to ten has been acceptable since it is very simple to repeat the coagulation procedure. We have been able to achieve relief of pain in all patients despite the occasional necessity of repeating the coagulation prior to discharge from the hospital.

The acceptance of this procedure by the patients has been uniformly good and the undesirable side effects are few in number. They consist if disagreeable sensory changes in the face 5 percent; difficulty with chewing 7 percent; diminution of sensation of cornea 20 percent; and corneal ulceration 2 percent.

In conclusion, we feel that this procedure provides a safe and effective method for the relief of trigeminal neuralgia.



Dr. Marion Vujevich, center, receives the Bronze Award in the field of original investigation for his exhibit, "Biological Assay of a New, Nonfluorinated Topical Corticosteroid for Its Inhibition of Inflammation." On the right is Dr. P. John Robechek, 1971-1972 OSMA President, and adding the distaff touch to the presentations is Mrs. Robechek.

Topical Corticosteroid Exhibit Wins Bronze Award

The exhibit, "Biological Assay of a New, Nonfluorinated Topical Corticosteroid for Its Inhibition of Inflammation," was given the Bronze Award in the field of original investigation. It was sponsored by Marion Vujevich, M.D., of the Department of Dermatology, University of Cincinnati College of Medicine. Following is a description of the exhibit and the background of information it represented, as written by the sponsor.

In dermatology, we are often deluged with an enormous amount of topical corticosteroids many of which are promoted as being more efficacious than their competitors. In support of these claims the "vasoconstrictor test" is often mentioned. The work that I have done clearly diminishes this test as the sole criteria and even suggests that in reference to topical corticosteroids, the term "vasoconstrictor" is a misnomer.

The purpose of the exhibit was twofold: first, to define the nature of the erythema in experimentally induced inflammation of the skin; and secondly, to present the morphological concomitants of inflammation affected by the topical application of a new, nonfluorinated topical corticosteroid. (tridesilon 0.05%).

In evaluation of topical corticosteroids, the blanching (pallor) produced in experimentally induced inflammation is often equated with vasoconstriction. Indeed, this inference is carried even further to postulate it as the entire mechanism of inflammatory inhibition effected by a corticosteroid. Reference cited to substantiate this mechanism of action may well be observations of secondary events, rather than of the primary mode of activity.

In an earlier double-blind study evaluating an experimental nonfluorinated corticosteroid (tridesilon 0.05%) in comparison with the vehicle, it was observed that the diminution of erythema at the site of artificially induced inflammation was not associated with any vasoconstriction visible by capillaroscopy. Therefore, a more detailed study was initiated to define the parameters that are used in the evaluation of topical corticosteroids and to elucidate the possible mechanisms of inhibition of inflammation.

It was found that stripping of previously normal skin results in acute inflammation. This process involves primary dilation of the metarterioles and precapillary sphincters as well as opening of previously closed capillary loops. This is perceived

grossly as erythema. The findings in this study confirm this premise.

Previous reports in the literature equate the diminished erythema noted after topical applications of corticosteroids with vasoconstriction. Objectively, the results of this study are at variance with these investigators on this subject but concur with the detailed work of Wells who noted and recorded less vasodilation. In other words the caliber of the vessels returned to normal size and did not appear to constrict.

Another investigator found no differences in skin temperatures or blood flow using radioactive xenon in corticosteroid-treated areas of inflammation. In this study, a preservation of vessel caliber in the subpapillary plexus following the application of topical corticosteroid was observed, despite the decrease in erythema evident macroscopically. The only significant difference to account for this discrepancy was in the relative number of filled capillary loops which can only passively open and close. In the noncorticosteroid-treated sites, the increase in erythema was associated with an increased number of filled capillary loops. Interestingly, studies with mecholyl suggest that blanching in atopic individuals represents an outpouring of edema fluid rather than vasoconstriction as previously thought.

Tissue damage in inflammation is known to result in increased vascular permeability and causes the release of "chemical mediators." These mediators produce secondary events such as dilatation of small vessels, further increase of vascular permeability, and leukotaxis. Although the mechanism by which corticosteroids exert their total anti-inflammatory activity remains largely unknown, this study demonstrates that desonide inhibits two components of the inflammatory process, namely, leukotaxis and vasodilatation.

In this biological assay, the degree of erythema was not related to the caliber of the vasculature but rather to the relative numbers of filled capillary loops. The mechanism of the inhibition of inflammation exhibited by desonide 0.05 percent may have been antagonistic activity against one or more of the "chemical mediators" of inflammation. This was demonstrable morphologically by a failure to increase the number of filled capillary loops and by a lesser degree of perivascular leukocytic infiltration.

Exhibit on Esophagus Replacement Wins Bronze Award

The Bronze Award in the teaching field was presented to the exhibit entitled "Esophagus Replacement with Reversed Gastric Tube," sponsored by Henry J. Hemlich, M.D., of the Esophagus Center, The Jewish Hospital, Cincinnati; and William C. Gardner, M.D., of The Trover Clinic, Madisonville, Ky.

The RGT (reversed gastric tube operation) provides a gastric pedicle tube long enough and



Bronze Award winner in the teaching field was the exhibit entitled, "Esophagus Replacement with Reversed Gastric Tube." Here Dr. Henry J. Hemlich one of the sponsors, receives the award from Dr. Jerry L. Hammon, member of the Committee on Scientific Work.

with an adequate blood supply to enable the entire esophagus to be replaced. Personal experience with this procedure in a series of 54 consecutive patients operated on over a 15 year period, from 1956 to 1972, is presented. Patients have been able to eat normally for as long as 13 years after RGT. Morbidity and mortality (5.5 percent) are satisfactorily low. The RGT, when used in children, grows normally.

By means of sculptured models, the surgical technique is demonstrated. In this one stage procedure, a stapling instrument is used to construct a tube from the greater curvature of the stomach equal to the length and diameter of the normal esophagus. This gastric tube, which remains attached at the fundus of the stomach, is reversed in direction, and then its antral end is anastomosed to the proximal end of the divided cervical esophagus or to the pharynx. The vascular supply to the greater curvature of the stomach is augmented by ligating the splenic vessels distal to the origin of the left gastroepiploic vessels and performing splenectomy. The entire splenic blood supply is thereby diverted to the greater curvature of the stomach, and the absence of the spleen permits sufficient mobility of the gastric tube to allow it to easily reach the pharynx.

The RGT has been used successfully for replacing the esophagus in the following conditions:

Benign Diseases

1. Strictures of the esophagus at any level caused by esophagitis or swallowing caustics.

2. Congenital lesions, e.g., atresia or tracheoesophageal fistula.

3. Hemorrhage due to esophagitis or bleeding varices in children.

Carcinoma

The RGT is contraindicated for carcinoma of the lowest third of the esophagus since the stomach must be partially resected. It is the procedure of choice in all other carcinomas involving the esophagus:

1. Carcinoma of the cervical esophagus. The RGT reaches the base of the tongue, permitting more adequate resection above and below the carcinoma than can be accomplished with other methods of esophageal reconstruction.

2. Carcinoma of the larynx or trachea involving the esophagus. When laryngectomy is necessary, "esophageal" voice is possible by using the newly constructed esophagus.

3. Carcinoma of the middle and upper thirds of the thoracic esophagus. The lesion is irradiated, then the esophagus is bypassed with the RGT, followed by total esophagectomy in two to three weeks.

Other Presentations

This exhibit was presented before the American College of Surgeons 57th Annual Clinical Congress in Atlantic City, October 18-22, 1971 and at the American Medical Association 121st Annual Convention, San Francisco, June 18-22, 1972. It was scheduled to be presented at the Kentucky Medical Association Annual Meeting in Louisville, September 18-21, 1972 and at the American College of Surgeons 58th Annual Clinical Congress, San Francisco, October 2-6, 1972.

Motion Pictures

A motion picture entitled, "Esophageal Replacement with a Reversed Gastric Tube," was awarded the Madaglione Di Bronzo Minerva, at the Fourth International Festival of Medical-Scientific Films, Turin, Italy, June 1961.

A motion picture entitled, "Reversed Gastric Tube Esophagoplasty Using Stapling Technique," won the American Medical Association Award for selected presentation at the 115th AMA Annual Convention in Chicago, 1966. This film is available from: The Dysphagia Foundation, The Esophagus Center, The Jewish Hospital, Cincinnati 45229. It is distributed to foreign countries by the United States Information Agency, Motion Picture and Television Service, Washington, D.C. 20547.

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5. Heimlich HJ: Carcinoma of the cervical esophagus. *The Journal of Thoracic and Cardiovascular Surgery,* **59**:309, March 1970.

6. Heimlich HJ: Esophagitis: Complications treated by total bypass without esophageal resection. *Annals of Thoracic Surgery,* **10**:203, September 1970.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

BUTLER
Jesus L. Licuanan
Hamilton

CUYAHOGA (Cleveland except as noted)
John H. Bauman
Berea
David N. Cohen
Shanta Nee-Nair
Kampani
Chin-Wook Lee
J. Dennis Morton
Upendra H. Patel
T. Pringpuangkeo
Jeffrey H. Rudell
Robert M. Rudisill
Thomas J. Wasserbauer

GREENE
Akbar Vafaie
Yellow Springs

HOCKING
Kenneth P. Turner
Logan

JEFFERSON (Steubenville except as noted)
Santiago Ching
Constantine V. Katsaros
Amsterdam
Joseph J. Macedonia
David S. Sanchez
W. Hunter Vaughan

LICKING
Michael P. Ratterman
Granville
Nicholas E. Reed
Newark

MONTGOMERY (Dayton)
William A. Bernie
Prem Singla

SCIOTO
Querico D. Doronila
Wheelersburg

SUMMIT (Akron, except as noted)
Sung Hak Chang
Barry Jay Greenberg
Dennis R. Lane
Kwangshin Lee
Cleveland
William M. Stitt
Luis Yap Yatco Tan
James E. Wilkerson
Cuyahoga Falls

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portant Note: This drug is not a simple analgesic. not administer casually. Carefully evaluate patients fore starting treatment and keep them under close pervision. Obtain a detailed history, and complete ysical and laboratory examination (complete mogram, urinalysis, etc.) before prescribing and at quent intervals thereafter. Carefully select patients, oiding those responsive to routine measures, con- indicated patients or those who cannot be observed quently. Warn patients not to exceed recommended sage. Short-term relief of severe symptoms with smallest possible dosage is the goal of therapy. sage should be taken with meals or a full glass of lk. Patients should discontinue the drug and report mediately any sign of: fever, sore throat, oral sions (symptoms of blood dyscrasia); dyspepsia, lgastric pain, symptoms of anemia, black or tarry ols or other evidence of intestinal ulceration or morrhage, skin reactions, significant weight gain or ema. A one-week trial period is adequate. Discon- ue in the absence of a favorable response. Restrict atment periods to one week in patients over sixty. *dications:* Acute gouty arthritis, rheumatoid arthritis, eumatoid spondylitis.

ntraindications: Children 14 years or less; senile tients; history or symptoms of G.I. inflammation or ceration including severe, recurrent or persistent spepsia; history or presence of drug allergy; blood scrasias; renal, hepatic or cardiac dysfunction; pertension; thyroid disease; systemic edema; matitis and salivary gland enlargement due to the ug; polymyalgia rheumatica and temporal arteritis; tients receiving other potent chemotherapeutic ents, or long-term anticoagulant therapy.

rnings: Age, weight, dosage, duration of therapy, istence of concomitant diseases, and concurrent tent chemotherapy affect incidence of toxic reac- ns. Carefully instruct and observe the individual tient, especially the aging (forty years and over) o have increased susceptibility to the toxicity of the ug. Use lowest effective dosage. Weigh initially predictable benefits against potential risk of severe, en fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.
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For complete details, including dosage, please see full prescribing information.

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Though Talwin® Tablets, brand of pentazocine (as hydrochloride), can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. Patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with meperidine or codeine. And that, in the long run, can mean a better outlook for your chronic-pain patient.

Talwin Tablets are:

- **Comparable to codeine in analgesic efficacy:** one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- **Tolerance not a problem:** tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- **Dependence rarely a problem:** during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- **Not subject to narcotic controls:** convenient to prescribe – day or night – even by phone.
- **Generally well tolerated by most patients:** infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects tend to be self-limiting and to decrease after the first few doses. (See last page of this advertisement for a complete discussion of adverse reactions and a brief discussion of other Prescribing Information.)

50 mg. Tablets

Talwin®

brand of **pentazocine** (as hydrochloride)

the long-range analgesic

a new outlook in chronic pain

of moderate to severe intensity



Contraindications: Talwin, brand of pentazocine (as hydrochloride), should not be administered to patients who are hypersensitive to it.

Warnings: *Head Injury and Increased Intracranial Pressure.* The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used wi caution in patients about to undergo surgery of the biliary tra

Patients Receiving Narcotics. Talwin is a mild narcotic antagoni Some patients previously receiving narcotics have experienced mi withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administer to patients prone to seizures; seizures have occurred in a few su patients in association with the use of Talwin although no cause a effect relationship has been established.

Adverse Reactions: Reactions reported after oral administrati of Talwin include *gastrointestinal:* nausea, vomiting; infrequent constipation; and rarely abdominal distress, anorexia, diarrh *CNS effects:* dizziness, lightheadedness, sedation, euphoria, hea ache; infrequently weakness, disturbed dreams, insomnia, syncop visual blurring and focusing difficulty, hallucinations (see *Acu CNS Manifestations* under WARNINGS); and rarely tremor, irr tability, excitement, tinnitus. *Autonomic:* sweating; infrequent flushing; and rarely chills. *Allergic:* infrequently rash; and rare urticaria, edema of the face. *Cardiovascular:* infrequently decrea in blood pressure, tachycardia. *Other:* rarely respiratory depressio urinary retention.

Dosage and Administration: *Adults.* The usual initial adult dose 1 tablet (50 mg.) every three or four hours. This may be increas to 2 tablets (100 mg.) when needed. Total daily dosage should n exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in ad tion to analgesia, aspirin can be administered concomitantly wi Talwin.

Children Under 12 Years of Age. Since clinical experience in ch dren under 12 years of age is limited, administration of Talwin this age group is not recommended.

Duration of Therapy. Patients with chronic pain who have receiv Talwin orally for prolonged periods have not experienced wit drawal symptoms even when administration was abruptly disc tinued (see WARNINGS). No tolerance to the analgesic effect h been observed. Laboratory tests of blood and urine and of liver a kidney function have revealed no significant abnormalities aft prolonged administration of Talwin.

Overdosage: *Manifestations.* Clinical experience with Talwin ov dosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and oth supportive measures should be employed as indicated. Assisted controlled ventilation should also be considered. Although nal phine and levallorphan are *not* effective antidotes for respirato depression due to overdosage or unusual sensitivity to Talwin, pa enteral naloxone (Narcan®, available through Endo Laboratories) a specific and effective antagonist. If naloxone is not available, pa enteral administration of the analeptic, methylphenidate (Ritalin may be of value if respiratory depression occurs.

Talwin is not subject to narcotic controls.

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DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1973 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be Monday through Wednesday, May 7, 8 and 9.

Mail applications to the attention of Jerry J. Campbell, Exhibit Manager, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

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1973 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 7, 8 and 9

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4. Booth Requirements: Back wall _____ (indicate footage) All side walls are 6′ deep
5. Description of Exhibit: (Attach 200 word description to this blank)

Deadline For Filing Applications, February 1, 1973

Sports Medicine Institute Covers Variety of Topics

MORE THAN 75 PHYSICIANS attending the Fifth Postgraduate Institute on Sports Medicine at the Center for Tomorrow in Columbus, August 2-3 were treated to a variety of timely topics.

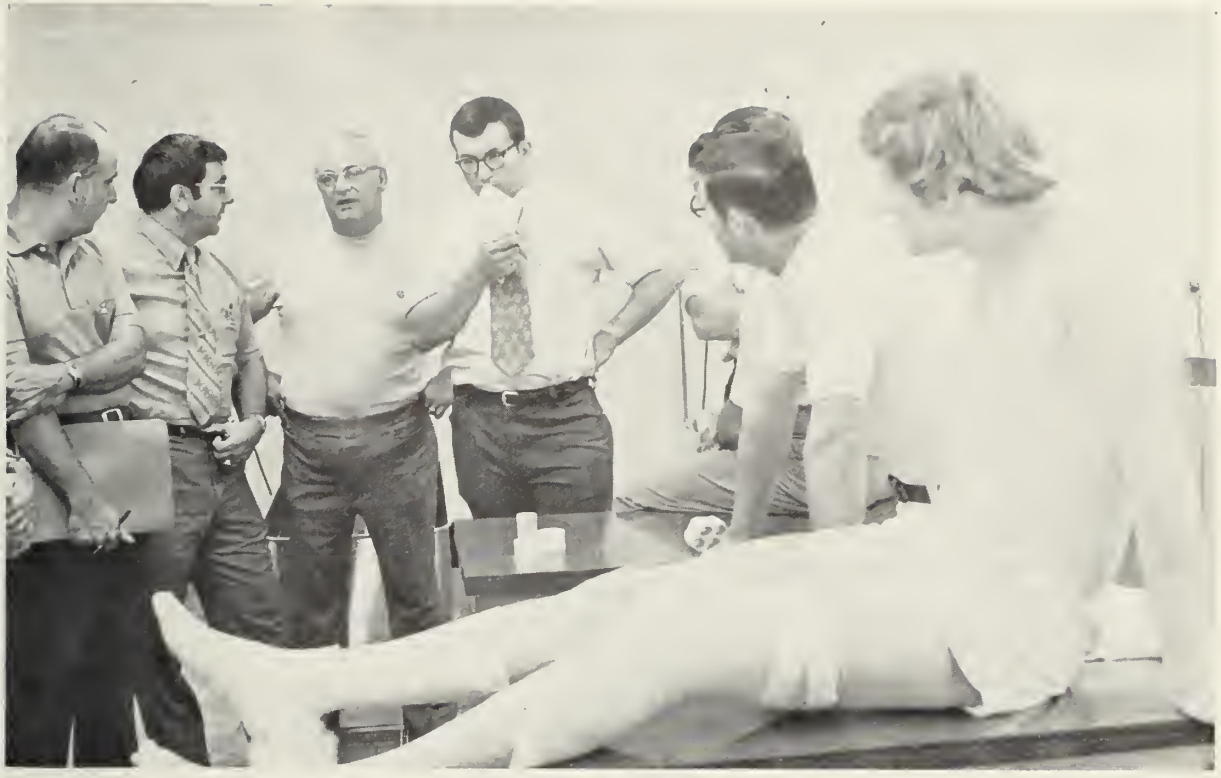
Cosponsored by OSMA, the Ohio State University College of Medicine and the Ohio High School Athletic Association, the two-day session highlighted insurance aspects of high school athletics, sports medicine on the national scene, relationship of coach and team physician, field decisions, treatment of shoulder and knee injuries, and a special half-day rotating seminar at the Biggs Athletic Facility, the Ohio State University.

The latter session included half-hour programs on basic taping techniques, football equipment, care of the eye, dental protection and prevention of heat illness.

Program chairman for the institute was Robert J. Murphy, M.D., of Columbus, head team physician for the Ohio State University and a member of the Joint Advisory Committee on Sports Medicine of OSMA and the OHSAA. Participants were welcomed to the institute by Sol Maggied, M.D., of West Jefferson, chairman of the Joint Advisory Committee. Other program participants included Harold A. Meyer, Ph.D., Worthington, commissioner of the OHSAA; Thomas E. Shaffer, M.D., Columbus, immediate past chairman of the Committee on Medical Aspects of Sports of the American Medical Association and



Use of sling psychrometer to determine wet bulb temperature is demonstrated to physicians attending Fifth Postgraduate Institute on Sports Medicine by Robert J. Murphy, M.D., right, head team physician for the Ohio State University and member of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association. Extremely high wet bulb temperatures demand alterations in football practice routines in order to protect players from heat illness.



W. W. "Woody" Hayes, third from left, head football coach at the Ohio State University, chats with physicians during seminar on basic taping techniques at Fifth Postgraduate Institute on Sports Medicine. Serving as the "model" for the taping demonstrations at right was Greg Hare, starting quarterback for Hayes' 1972 Buckeye team. Second from right is Head Athletic Trainer Al Hart who performed the demonstrations.

member of the Joint Advisory Committee; W. W. "Woody" Hayes, head football coach, the Ohio State University; James F. Mason, M.D., team physician, Upper Arlington High School; Judson D. Wilson, M.D., Columbus; H. Royer Collins, M.D., Cleveland; Richard Patton, M.D., Columbus; Joseph T. Leach, M.D., Columbus; Mr. Al Hart, head athletic trainer, the Ohio State University; Mr. John Bozick, equipment manager, OSU Department of Athletics; Allen W. Hall, D.D.S., associate professor, the Ohio State University College of Dentistry; Robert H. Magnuson, M.D., Columbus; John N. Meagher, M.D., Columbus and Melvin L. Olix, M.D., Columbus.

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Obituaries

Lynne Elmer Baker, M.D., Dayton; University of Cincinnati College of Medicine, 1935; aged 66; died August 10; member of OSMA, AMA, and American Thoracic Society; Fellow, American College of Chest Physicians; practitioner in Dayton since 1935, specializing in chest diseases; past president of the Montgomery County Medical Society and past president of the Montgomery-Greene TB and Respiratory Disease Association.

Joseph Lupe Bilton, M.D., Cleveland; Hahnemann Medical College of Philadelphia, 1937; aged 60; died August 8; member of OSMA and AMA; Fellow, American College of Surgeons and International College of Surgeons; diplomate, American Board of Surgery; practicing surgeon in Cleveland for a number of years; served with the U.S. Navy Medical Corps during World War II; president of the Academy of Medicine of Cleveland; delegate of the Academy to the OSMA House of Delegates; past president of the Cleveland Surgical Society.

James Russell Bone, M.D., Chillicothe; Hahnemann Medical College of Philadelphia, 1938; aged 61; died August 7; former member of OSMA; practitioner in Chillicothe since 1955, specializing in anesthesiology and industrial medicine; served in the U.S. Air Force during World War II and after the war practiced in Cincinnati.

Thomas Hartwell Brown, Sr., M.D., Toledo; Vanderbilt University School of Medicine, 1915; aged 82; died August 3; member of OSMA and AMA; Fellow, American College of Surgeons; orthopaedic surgeon in Toledo for many years before his retirement four years ago; past president of the Academy of Medicine of Toledo and Lucas County; veteran of World War I. His son, Dr. Thomas H. Brown, Jr., is a practicing physician in Toledo.

Joseph Wallace Ewing, M.D., Akron; University of Louisville School of Medicine, 1942; aged 64; died August 4; member of OSMA and AMA; practitioner in Akron for a number of years, specializing in plastic surgery; veteran of World War II.

Ford Carter Ganyard, M.D., Wooster; Loyola University Stritch School of Medicine, 1918; aged 79; died July 28; member of OSMA, AMA, and American Geriatrics Society; practicing physician of long standing in the Wooster area; former member of the Wayne County Department of Health.

Glenn C. Hoffman, M.D., Dayton; University of Louisville School of Medicine, 1950; aged 60; died August 17; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in the Dayton area for 21 years.

Leo Morton Levin, M.D., Miami Beach, Florida; Ohio State University College of Medicine, 1934; aged 64; died July 30; practitioner in Cleveland until about 1946 when he moved to Florida; specialist in internal medicine.

John Edgar Linden, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1911; aged 84; died August 7; member of OSMA and AMA; practitioner for more than 60 years in the Pearl-Broadview area of Cleveland, where his father, the late Dr. Washington E. Linden also practiced; veteran of World War I.

Constantine H. Solomonides, M.D., Columbus; Ohio State University College of Medicine, 1922; aged 78; died August 21 after suffering a heart attack while returning from a trip to his native Greece; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner of long standing in Columbus.

Harvey Newell Trumbull, M.D., Columbus Grove; Toledo University Medical Department, 1910; aged 88; died August 10; member of OSMA and AMA; general practitioner for many years in the Columbus Grove area before his retirement; veteran of World War I.

Merrill John Werner, M.D., Dayton; University of Illinois College of Medicine, 1933; aged 68; died August 9; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner in the Dayton area for more than 20 years; veteran of World War II.

Robert H. Zeis, M.D., Kenton; Ohio State University College of Medicine, 1934; aged 64; died July 29; member of OSMA and AMA; native of Hardin County and practitioner there for all of his professional career, first in Mt. Victory, and from 1942 in Kenton.

Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

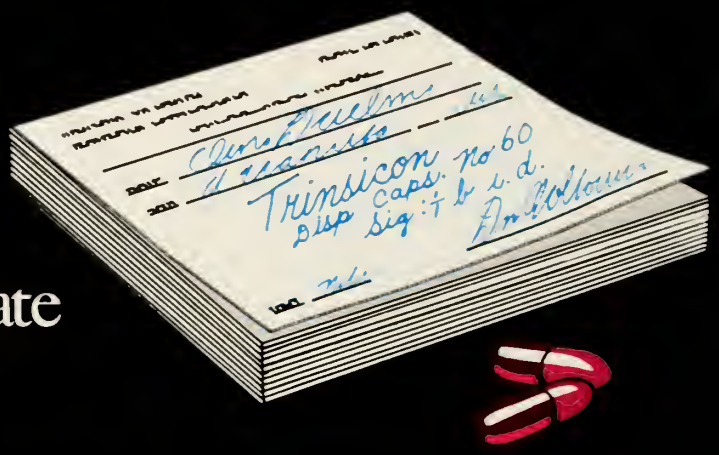
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Hematinic Concentrate with Intrinsic Factor

(See reverse side for prescribing information.)

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Hematinic Concentrate with Intrinsic Factor



Description: Each Pulvule® contains—

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Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.

(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	0.5 mg.

Indications: Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

Vitamin B_{12} with Intrinsic Factor—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B_{12} in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B_{12} leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B_{12}. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B_{12} deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B_{12} contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B_{12}) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

Folic Acid—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B_{12} deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B_{12} interrelationship: (1) B_{12} influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B_{12} progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B_{12}.

Iron—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

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Ascorbic Acid—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

Contraindications and Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B_{12}-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B_{12} may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

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Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

"OPEN A NEW DOOR—follow a new highway" sounds the theme for the 1972 Fall Workshop to be held at the Hospitality Motor Inn in Columbus on October 24. This is the annual working get-together of county officers, county chairmen and the State Board.

Here is the way the day will be scheduled, beginning with the Continental Breakfast and Registration from 8 to 9 a.m.:

9-9:15 a.m.—Opening Session — Mrs. Karl Ulicny presiding

9:15-9:45 a.m. — Film "They're Leaving Us All the Time" narrated by Mrs. John Sugg

9:45-10:25 a.m. — Keynote speech — Robert Kaplan, Ph.D., Professor of Health Education, Ohio State University—"Health Education—What and Why"

10:30-10:55 a.m.—Nutrition, What and How —Mrs. Robert E. Krone

11:00-11:30 a.m. — Work Sessions

"Hot Line" (Teen-Age VD and Drug Abuse)—Mrs. Albert May

Safety—Mrs. F. M. Freimann

Health Education Conference—"how to" procedures and program suggestions—Mrs. Armin Melior

11:35-12:00 p.m. — Same work sessions repeated

12:05 p.m.—Social time with district directors

12:30 p.m.—Luncheon

1:15 p.m.—Speaker—Dr. Effie Ellis, special assistant to the AMA Executive Vice-President

1:50 to 2:25 p.m.—Three Concurrent Workshops

Auxiliary News and Publicity—Mrs. S. J. Glueck and Mrs. S. L. Meltzer

International Health—Mrs. Howard E. Smith

Health Manpower—Mrs. Jack Weiland

2:30-3:05 p.m.—Three Concurrent Workshops

Membership—Mrs. Daniel S. Wolff

AMA-ERF — Mrs. Henry Holden and Mrs. R. A. Wiltsie

Legislation—Mrs. S. B. Pfahl

3:10-3:30 p.m.—Speaker—Mrs. Emily Leedy —director, Women's Division of the State Employment Service—"Legislation for Women and What Our Future Role Can Be"

3:30 p.m.—Adjournment and Coke Time

There will be a State Board meeting on Monday, October 23rd, at 12:30 p.m., followed by a 6:00 p.m. dinner. The evening will be devoted to an informal talk and discussion by Dr. Ellis and the showing of several films with timely comments.

All of the foregoing adds up to a vitally important approach to meaningful and significant

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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New Philadelphia, 44663

auxiliary activity on behalf of the medical profession.

Speakers' Bureau

The State Board is deeply indebted to the Ohio State Medical Association for the Speakers' Bureau workshop that was held in Columbus on September 21st and 22nd at the Sheraton Columbus hotel. Dr. Robert Lang, executive secretary of the Academy of Medicine of Cleveland, a member of the AMA Speakers' Bureau, directed the training seminar for interested auxiliary members. Mrs. Christopher Colombi, state program development chairman, worked with the OSMA in setting up this much needed project.

To quote Mrs. Colombi: "let us help in this positive approach emphasizing the public education link in the Health Care Delivery chain." Subject material is being supplied by the OSMA and speakers from the auxiliary will be made available for talks before lay groups.

Nor must I forget to extend our further gratitude to "Suite 500" at 17 South High Street for the delightful social hour and dinner that Thursday evening.

NOW is the time!

All of us know perfectly well that the privilege to vote for the man or woman of our choice cannot be measured in any terms, so priceless is it. Yet ironically, there are some people who need to be reminded and reminded and urged to vote—a fact which is rather startling, when one thinks about it!

Still another reminder: The last day for voter registration is October 10th. You have to be registered to vote. All registered adults and youths eighteen by November 7th can vote—and most assuredly, **should** vote! Remember that you must have had residence in Ohio for 30 days prior to November 7th. And if you have moved from one county to another, the 30-day residency is also required.

Woman In The News

The little lady in question didn't send me the newspaper clipping about herself, but thanks to Jane Sloan, I have before me the feature story in the *Dayton Daily News* whose headline reads "She'll Fight for CSU's Med School."

"She" is Mrs. S. J. Glueck, of Springfield, third vice-president of our state auxiliary and editor of the *Ohio Medical Auxiliary News.* Charlotte was recently appointed by Governor Gilligan to the board of trustees at Central State University. Although she is not the first female to serve on the board, she is the only woman on the board's current term.

According to the newspaper story, Central State is engaged in a struggle for a medical school. Charlotte says "my ears perk up when you mention medical school. I'm very interested in Central State taking part in it." She went on to say that she is "very, very interested in higher education . . . . I plan to get acquainted with the campus and get to know it better and am amiable to attending anything they ask me to."

Charlotte will be the fourth non-black member on a nine-person board at the predominantly black school. "I don't know why there should be any problems," Mrs. Glueck commented. "When I judge a man or a woman, I don't judge on the basis of whether they are black or white."

"Call The Doctor"

Mrs. Carl F. Schilling and Mrs. Robert E. Krone appeared on Cincinnati's popular one-hour



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10-10

panel show "Call The Doctor" on Sunday, October 1. This program, sponsored and conducted by the Cincinnati Academy of Medicine, is carried on WCPO-TV and WHIO-TV and is also available on cable television in a number of areas (here in Portsmouth, I am one of its most faithful viewers!) It's a terrific program.

Mrs. Schilling, chairman of the nursing and health program of the American Red Cross in Cincinnati, chose the theme of health education for the television show. Emphasis was on the responsibility of individuals for their own good health. Mrs. Schilling pointed out that the Red Cross offers many programs and classes that teach people what they can do for themselves.

Mrs. Krone, a state auxiliary director at large and chairman of our state committee on nutrition, is a registered dietitian. She answered questions about nutrition services. Other panelists on the television program included a family physician, a psychiatrist and a registered nurse—Mrs. Schilling. She is a member of the Hamilton County auxiliary, as is Mrs. Krone. Dr. Schilling served as moderator and directed the questions telephoned in to members of the panel.

County Talk

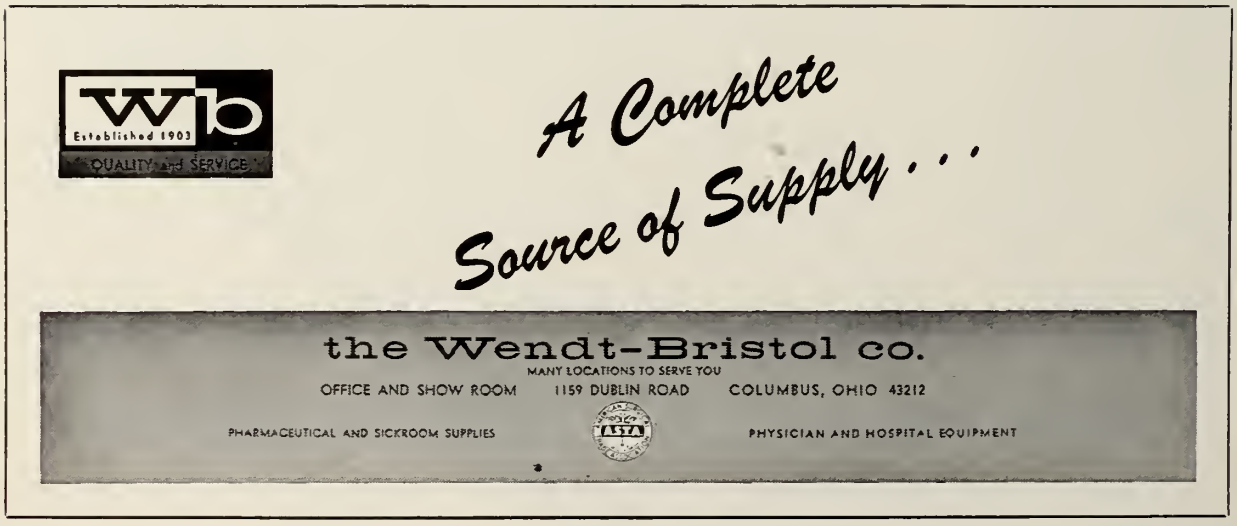
It was a champagne luncheon for the **Franklin County** auxiliary on September 19 at the Oakhurst Country Club. Auxiliary members served as lovely models for the style show presented by Town and Country.

Nurse scholarships have been awarded in Franklin County to Cynthia Burchett of Mt. Carmel Hospital and to Susan Evans and Raye Lynn Wilson of Grant Hospital. There was an especially nice letter recently from Mary Shal, a scholarship recipient for the past two years, thanking the auxiliary and stating that she will be working at Mt. Carmel. Said Miss Shal: "I truly enjoyed meeting and talking with the wonderful people who have been so kind to me. Your organization is a great asset to the Columbus community and I am grateful to have become acquainted with its members."

An Anniversary

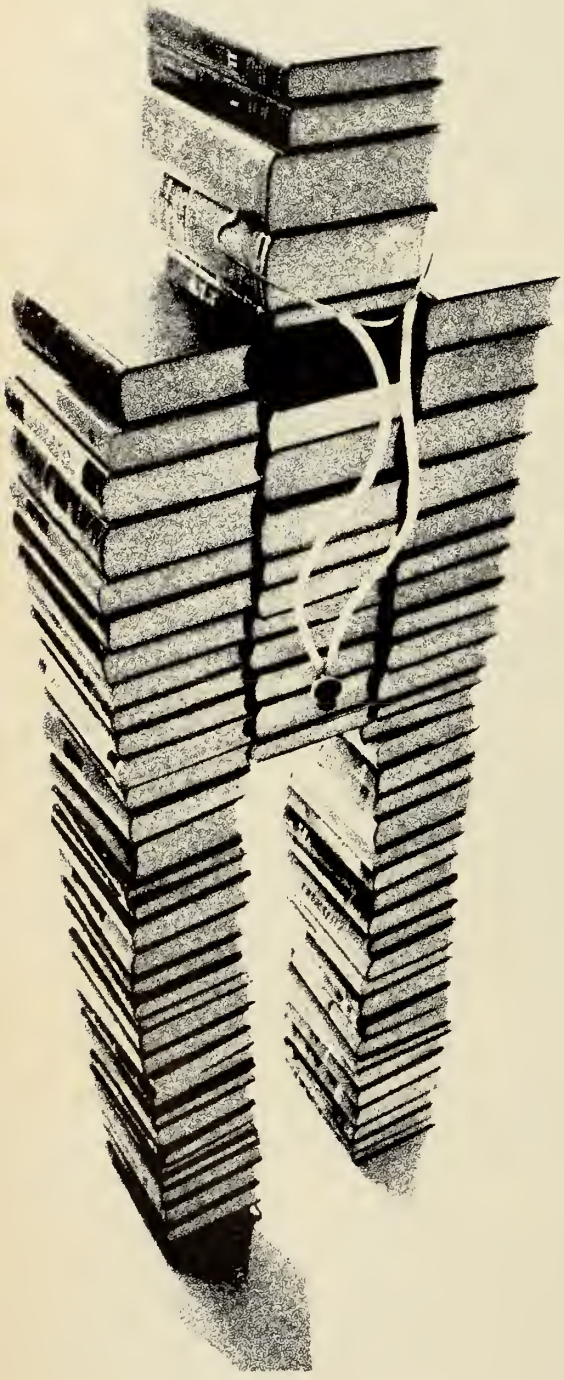
Congratulations to the **Montgomery County** auxiliary on its silver anniversary. Mrs. Donald A. Buck, president, has chosen as her year's theme "Up with People" and the attractive yearbook bears testimony to the ingenuous selection of topics for the year's meetings. Here they are: "Up with Community Health"; "Up with Professional Friendships"; "Up with Statewide Ideas"; "Up with Local TV"; "Up with Auxiliary Community Participation"; "Up with Understanding Ourselves"; "Up with Professional Knowledge"; "Up on Your Toes"; "Hang-Up"; "Up with the New"; "Up with the Old"; "Up with Future Health"; "Up with Togetherness"; "Up with Creativity"; "Up with Leadership"; "Up to the End." Certainly sounds provocative, doesn't it?

Of course, we'll be bringing you all the details as the months roll by. It certainly sounds as if Montgomery County is going to have a banner twenty-fifth year!




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(Continued from Previous Page)

PHYSICIAN WANTED: OB. GYN. Board eligible or certified for association with certified OB.GYN. private practice in expanding eastern suburb Cleveland; office close to modern hospital with M.D. anesthesia. Area is 18 miles from university. Submit credentials to: Daniel Thanos, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094.

RADIOLOGIST — New Regional Medical Center open 1973. Present Radiologist will share Nuclear Medicine, Diagnostic X-Ray and special procedures. Compensation negotiable and depends on training & experience. J. R. Manchester, M.D., Box 756, Chillicothe, Ohio 45601.

PHYSICIAN with general practice or internal medicine background needed for fully accredited 1000 bed psychiatric hospital. Convenient location between Cleveland and Akron. Pleasant working conditions. Recent salary increases and attractive fringe benefits. Ohio license necessary. Call collect (216) 467-5663 or write Eliere J. Tolan, M.D., Superintendent, Box 305, Northfield, Ohio 44067.

PSYCHIATRIST — COMMUNITY-ORIENTED STAFF PSYCHIATRIST Being sought to join a growing comprehensive mental health center which was the first in the state of Ohio. Responsibilities would include participation in the in-patient and out-patient services, as well as pursuit of own interests in consultation, community education, in-service training programs, etc. Competitive salary, excellent fringe benefits, and opportunity to contribute ideas and skills to a developing agency. Write Eugene Capocasale, M.D., Director, Muskingum Comprehensive Mental Health Center, 2845 Bell Street, Zanesville, Ohio, 43701, or call (614) 452-9553 collect.

CLINICAL CHILD PSYCHOLOGIST needed for staff position in the Child Study and Treatment Department of a progressive community mental health center. Responsibilities include some psycho-diagnostic testing, consultation with other agencies, participation in community education programs, and the provision of direct therapeutic services. Family therapy skills as well as play therapy skills are highly desirable. MS/MA plus two years experience are the minimal requirements. Salary is competitive and fringe benefits are excellent. Write Robert W. Birch, Ph.D., Clinical Services Director, Muskingum Comprehensive Mental Health Center, 2845 Bell St., Zanesville, Ohio, 43701, or call (614) 452-9553. An equal opportunity employer.

VACATION CONDOMINIUM — New Smyrna Beach, Fla. — just south of Daytona and away from the crowds, but enjoying the same beautiful beach. Two bedrooms, 2 baths, wall-to-wall carpeting, completely and tastefully furnished including linens, color TV and dishwasher, HEATED POOL, and sauna. $400 per month. For reservations or further information, contact Wm. W. Conner, M.D., 517 Lakeshore Dr., Eustis, Florida 37626. Phone 904-357-5715.

EMERGENCY ROOM PHYSICIAN NEEDED — Established group of two full time and six part time physicians need third full time man for active emergency service. Incorporated. Salary very good and negotiable, leading to full partner status within six to twelve months. Excellent 300 bed general hospital in community of 45,000 only 40 miles from Columbus. Many fine specialists available for help and referral. Please contact: J. F. Barker, M.D., 614-344-0331, Newark, O.

THREE EMERGENCY ROOM PHYSICIANS WANTED to staff new E.R. facilities of 200 bed hospital. 50 man multispecialty Clinic physically adjacent provides immediate consultation and support. No pediatric responsibilities. Michigan resort city on Lake Michigan. Salary negotiable. Many fringe benefits. Reply to: John Rasmussen, Administrator, Burns Clinic Medical Center, P.C., Petoskey, Michigan 49700.

EMERGENCY ROOM PHYSICIAN WANTED to complete 5-man group. Present group successfully servicing 2 accredited hospitals. $30,000 annual guaranteed salary. Ohio license required and fluency in English. Could be opportunity for physician completing residency in surgery or other specialty to become known in community prior to establishing private practice. Hospitals will assist with relocation. If interested, write Mr. L. E. Thompson, Administrator, Scioto Memorial Hospital, 1805-27th Street, Portsmouth, Ohio 45662, and include brief resume.

OTOLARYNGOLOGIST - ORTHOPEDIC SURGEON needed immediately for solo practice; assistance from Physical Recruitment Fund available to help physician become established in community of 34,000 with service area of 115,000; two modern hospitals, fully accredited; industrial and agricultural base; excellent recreational facilities; close to metropolitan areas. Contact L. E. Thompson, Administrator, Scioto Memorial Hospital, 1805-27th Street, Portsmouth, Ohio 45662 (614) 354-2813.

PSYCHIATRIC RESIDENCIES — Excellent, approved psychiatric education; intellectually demanding and clinically diversified in a stimulating, well-balanced program. Affiliated with Michigan State University's College of Human Medicine. The setting is in a culturally rich community; the serene, scenic Grand Traverse Bay area. Three year plan: $12,820 to $14,574; Five year plan: $14,637 to $27,436. Contact Dr. Paul E. Kauffman, Director of Psychiatric Training, Room 167, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

EMERGENCY CENTER PHYSICIANS — full time, for Lake County Memorial Hospitals, Willoughby and Painesville, Ohio. $25,000 basic salary, plus opportunity for additional income. Liberal fringe benefits, including professional liability insurance. Must have Ohio license. Contact: W. E. Fletcher, M.D., 89 E. High Street, Painesville, Ohio 44077.

— More Classified Ads on Next Page —

CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

ASSOCIATE IN FAMILY MEDICINE, TOLEDO —Young dynamic family practice, modern well-equipped office. Must have boards or be working on same. For right physician "offer you can't refuse." I need help but am willing to wait for right person. Reply Box 657 c/o Ohio State Medical Journal.

FLORIDA APARTMENT FOR RENT—We have purchased on the Isle of Capri, a condominium on the Inland Waterway where it enters the Gulf, with a beautiful view of Marco Island and the Gulf from living room, bedroom and balcony. Since we can use it only approximately two months during a year, we are advertising to rent it by week or month to people we know about. It is completely equipped and sleeps one or two couples comfortably. Rate, depending on season, $100-$200/week, $300-$650/month. For more information, write or call Dr. Hal Barlow, 314 Ohio Building, Akron, Ohio 44308—telephone 216-253-8711.

FAMILY PRACTICE RESIDENCY — Just approved — openings at all levels — can start immediately — for details contact: A. J. Pultz, M.D., Chairman, Family Practice Committee, Grant Hospital, 309 E. State, Columbus, Ohio 43215.

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FOR SALE: Westinghouse Radiographic Fluoroscopic 60 MA X-ray Unit, tilting table, complete with accessories. In very good condition. Ideal for a beginner. I no longer do x-rays. Priced right. Write P.O. Box 526, Bainbridge, Ohio 45612 or Phone Bainbridge, Ohio 634-2481 any afternoon between 1:00 & 3:00, except Thursdays.

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DOCTORS INTERESTED IN FULL TIME EMERGENCY ROOM work, must have Ohio license. Contact Wm. E. Culbertson, Administrator of Wood County Memorial Hospital, Bowling Green, Ohio 43402.

STAFF PHYSICIAN — Specialist in either pediatrics, internal medicine or neurology preferred but will consider G.P. with a good background. Facility handles 1,200 mentally retarded residents with a wide range of problems. Plenty of professional challenge coupled with reasonable working hours make this an attractive position. Salary up to $32,280 depending on qualifications. Excellent fringe benefits provided by Michigan Civil Service. Send your curriculum vitae to: Donald Christensen, M.D., Mt. Pleasant State Home and Training School, P.O. Box 448, Mt. Pleasant, Michigan 48858. An Equal Opportunity Employer.

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TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

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impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS BUCCAL Tabs

Methyltestosterone N.F.-5 mg.

Android® 10

Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4 en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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Librium® and (chlordiazepoxide HCl) concomitant use

Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents, diuretics, anticholinergics and antacids.

Antianxiety effectiveness: Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable, appropriate levels.

Effect on mental acuity: Usually minimal on proper maintenance dosage.

Safety: An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

in relief of clinically significant anxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg, 25-mg capsules
up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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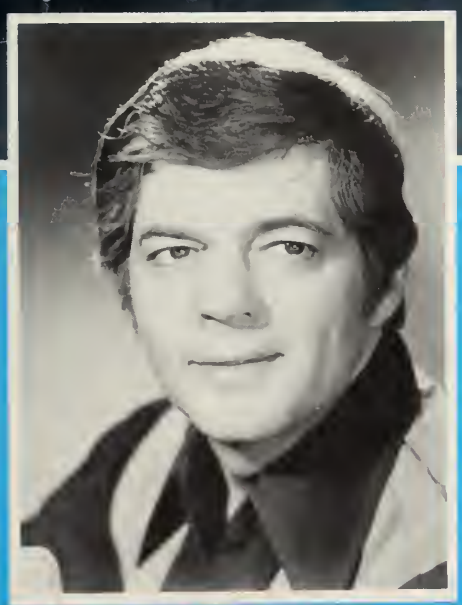
NOVEMBER • 1972
VOL. 68 NO. 11

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

Montgomery County Medical Society Glee Club To Entertain at Cincinnati AMA Convention





Starring
Bill Hayes
Vocalist
of Stage and Screen
See page 1045

EXCHANGE OFFICE
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The negative power of clinically significant anxiety in angina pectoris...



This man feels he is living on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

16 NOV 1972

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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The Ohio State MEDICAL JOURNAL

VOL. 68 NOVEMBER, 1972 No. 11

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In 1957 Beecham scientists discovered and isolated 6-APA, the penicillin nucleus that opened the way to a new generation of semi-synthetic penicillins. Over the past 14 years more than 3000 different semi-synthetic penicillins have been synthesized and evaluated by our staff. The fruits of their work are in your hands today. Others will be in your hands tomorrow.

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☐ Bactocill (sodium oxacillin) capsules equivalent to 250 mg. and 500 mg. oxacillin and vials for injection equivalent to 500 mg. and 1 gm. oxacillin.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

BUTLER (Hamilton)
David L. Bryant
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George T. Manitsas

CLARK (Springfield)
John R. Farrall
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Elyria
Sally Ryden
Elyria

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PUBLIC PRESS QUOTE

Socialized Medicine Fails

The British system of socialized medicine is often cited as a model by American political reformers, including Senator McGovern, who has made health care an issue in his presidential campaign.

But after 24 years of operation, Britain's National Health Service apparently still doesn't work all that well. It has come under such strong criticism at home that the Conservative government has proposed a complete overhaul of the entire program.

The principal areas of dissatisfaction read like a list of complaints against the American system of private medicine, including the refusal of doctors to make house calls, neglect of the aged, handicapped and mentally ill, and the lack of adequate hospital facilities outside the major cities.

Patients are also disturbed over long waits in the doctor's office and delays in scheduling major operations. As in any other government agency, a huge bureaucracy has grown up around the health service which the public finds insensitive to the needs of the patient.

To correct the situation, the Ministry of Social Services has proposed to decentralize the health service in order to give regional and local authorities a stronger voice in health care. Before American politicians push any trend to socialized medicine, they should note that the British system has proved so unsatisfactory that the government has issued a White Paper proposing to appoint a Health Ombudsman to deal with specific complaints of poor treatment by individual patients.

—*Youngstown Vindicator, August 6, 1972*

The Ohio Lions Eye Research Foundation presented a check for $17,745 to the Department of Ophthalmology, University of Cincinnati College of Medicine. It will help finance the department, headed by Dr. Taylor Asbury, and the Cincinnati Eye Bank for Sight Restoration Inc. This is the 20th year that the Ohio Lions Research Foundation has raised money for eye research. Its gifts to UC now total over $200,000.



4 October 1972

Ohio State Medical Journal
Dear Sirs:

Your recent published request for opinions concerning FDA actions is sufficient for me to feel the urge again to express my feelings. (Please refer to August issue of The Journal, page 748.)

With due regard to drug safety, this is not the only goal for drug use. Granted that Drug A may be the best drug for treatment of Disease X, it is effective in perhaps 95 percent of the cases. What do I do with the other 5 percent? For them I may need Drug B which has a greater potential for adverse reactions. I am willing to accept this risk in order to relieve the patient of his disease. It is in this area that the drug limitations can do the most harm. We need alternatives. Good medicine is "2 percent medicine"—not treating the 98 percent of patients with a disease who respond well, but curing the other 2 percent. Therein lies the challenge, and therein lies the difference between average medical care and excellent medical care. The FDA is taking away our options.

A further problem disturbs me. The scientific evaluation of drugs and therapy is essential in order to determine the best way to treat a particular disease. Scientifically tenable conclusions are certainly needed. However the scientists seem to forget that we practitioners treat patients; patients who have disease, true, but we do not treat the disease alone. For treating patients and people, as opposed to diseases, we need certain drugs which may have little or no pharmacologic effect. This in no way reduces their value, provided we do not deceive ourselves about how and why we use the drugs.

The important thing is not the drug; it is our knowledge of the drug. I believe we are capable of handling this without federal fiat.

Respectfully,
William J. Loeb, M.D.
Cleveland

Federal Grant Boosts Construction for Medical College at Toledo

The Medical College of Ohio at Toledo has received a federal grant for $4.9 million toward the construction of a health education building on the college's new campus.

College officials reported that the proposed building would cost $13.3 million, with the balance of $8.4 million furnished by state funds.

The award marks the first major federal grant to the Medical College of Ohio, and will prove a benchmark in the institution's future development.

The health education building was the second building planned for MCO's new campus, but probably will be the third building to be constructed.

The Health Sciences building is nearing completion and is expected to be occupied late this year. Bids were scheduled to be opened in September for the college library. If they fall within estimates, construction of the library — originally planned as building #3 — could begin soon. Both of these buildings are being funded by the state of Ohio.

The federal grant comes from the Division of Physician and Health Professions Education, Bureau of Health Manpower Education, of the National Institutions of Health.

Scholarships Would Aid Health Manpower Gap Areas

The Ohio State University Development Fund has received a grant of $100,996 from The Robert Wood Johnson Foundation of Princeton, N.J., to fund scholarships for women, minority and rural students enrolled in the College of Medicine.

The scholarships, to be distributed over four academic years, beginning in 1972-73, are part of the $10 million Robert Wood Johnson Foundation Student Aid Program for schools of medicine and osteopathy.

The program is designed to improve health services in rural and inner-city areas now inadequately served by health professionals. Officials believe that enrollment of women, students with rural backgrounds, and minority students will result in more students returning to work in areas where they are most urgently needed.

Ohio Communities Stake Medical Students in Return for Future Practice

Ohio communities have begun taking steps to alleviate physician shortages in their areas with the help of the Medical College of Ohio at Toledo.

Van Wert and Canton have launched programs that help finance a medical student's education, while the student in return agrees to set up practice in that community when his education is completed.

Under a similar program, Ohio Valley Health Services Foundation, Inc. (OVHSF), a nonprofit organization to attract professionals in health care to the Appalachia region of Ohio, has awarded a $3,500 study grant to a second-year student at MCO.

Dr. Howard S. Madigan, associate dean for continuing education, said, "The programs began a year ago in an effort to solve the physician shortage and distribution problems that face many communities in Ohio, while helping students finance their education."

Under the programs, MCO students Terry Johnson, of Mendon, has agreed to set up his practice in Van Wert, and James E. McMillian, of Canton, will return there. The OVHSF grant was awarded to Janet Brockwell, of Cambridge, who has agreed to serve in one of the seven participating counties: Athens, Gallia, Hocking, Jackson, Lawrence, Meigs, and Vinton.

Philip Pletcher, Ph.D., assistant dean of nonacademic student affairs at MCO, said: "In many instances students at MCO have a difficult time securing enough funds to finance their education. Student expenses — including room and board, transportation, books, tuition, hospital insurance, car insurance, clothing and professional instruments—on the average cost the single medical student at MCO $5,000 per year."

Under the Van Wert program, funds are raised from local medical and dental societies, the county hospital board, financial institutions, industry, and private sources, and are earmarked to be used as collateral to secure loans for the student.

MCO officials advise communities and students considering these practice-loan agreements, but the Medical College does not enter into the contract.

The Van Wert program set up guidelines which have attracted interest from other communities. Under these guidelines:

- The candidate makes a commitment to practice in Van Wert or the county, using Van Wert County Hospital as the primary facility.
- He must be in the final two years of his course work.
- The candidate must have taken advantage of all available government and student loan programs.
- After the loan has been secured, Van Wert funds will be used to pay for credit life insurance and interest on the loan, while the student is finishing his education.
- All incurred interest on the loan will be forgiven six months after the physician establishes his or her practice in Van Wert.
- The loan and insurance repayment period is not to exceed five years.
- If the student does not complete medical school, or does not practice in Van Wert, he will be liable for the principal amount of the loan, all interest incurred and all insurance payments.


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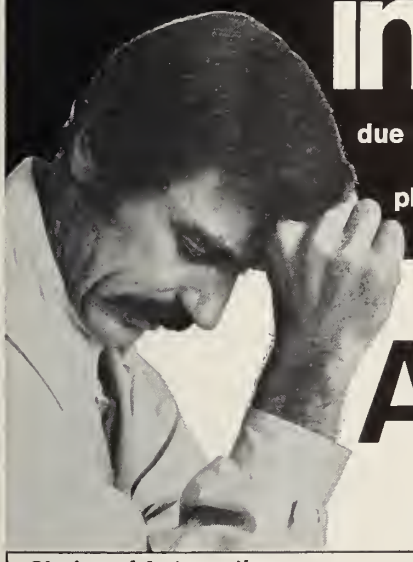
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Official Journal of the American Fertility Society



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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12-69, 1966. 2. Oublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5-67, 1964. 3. Titeff, A. S. Methyltestesterene-thyroid in treating impotence. Gen Prac 25-6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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U. S. POSTAL SERVICE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of August 12, 1970: Section 3685, Title 39, United States Code)

SEE INSTRUCTIONS ON PAGE 2 (REVERSE)

1. TITLE OF PUBLICATION: The Ohio State Medical Journal

2. DATE OF FILING: September 27, 1972

3. FREQUENCY OF ISSUE: Monthly

4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, city, county, state, ZIP code) (Not printers)*: 17 S. High St., Suite 500, Columbus, Franklin County, Ohio 43215

5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*: 17 S. High St., Suite 500, Columbus, Franklin County, Ohio 43215

6. NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and address)*: Ohio State Medical Association, 17 S. High St., Suite 500, Columbus, O. 43215

EDITOR *(Name and address)*: Perry R. Ayres, M.D., 17 S. High St., Suite 500, Columbus, Ohio 43215

MANAGER EDITOR *(Name and address)*: Mr. Hart F. Page, 17 S. High St., Suite 500, Columbus, Ohio 43215

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

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R. Gordon Moore

Executive Business Manager

PS Form 3526 July 1971

Huron Road Hospital Offers Hi Student Insight Lectures

Huron Road Hospital's award winning Medical Insight Lecture Series is being offered for the twelfth year to Greater Cleveland high school students. During the 1972-73 school year members of the Medical Staff of the hospital are devoting two Wednesday afternoons a month to the program which was cited recently by the Ohio Hospital Association. The hospital is located at 13591 Terrace Road, Cleveland 44112.

The first lecture was given in September by Dr. Paul Boyd, director of the Department of Urology, and dealt with a subject much in the news, vasectomy and its psychological effects.

Drug addiction versus alcohol addiction, homosexuality, marihuana, obesity and senility were covered by Dr. Victor Victoroff in October. Dr. Victoroff is chief of the Department of Psychiatry and chairman of the Education and Research Foundation of the Ohio Psychiatry Association.

On November 15 and 29th, Dr. E. A. Husni, associate director of the Department of Surgery, will discuss cardiovascular surgery and organ transplants.

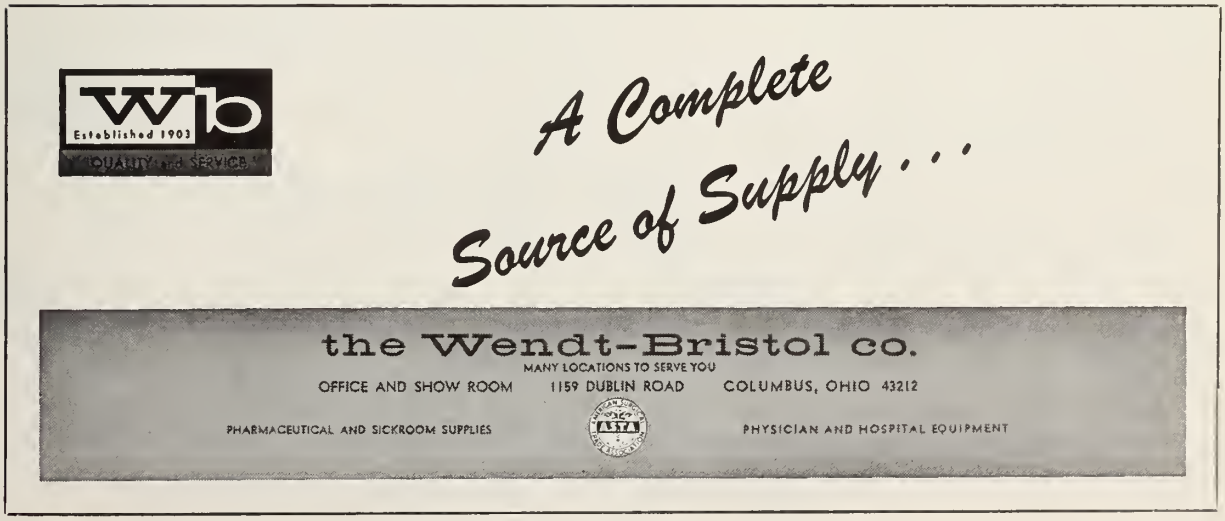
Noise pollution and its effect on hearing is the subject of the lecture to be given by Dr. Gilbert Erlechman, chief of the Ear, Nose and Throat Division. Dr. Erlechman will speak on December 6th and 13th.

A short seminar on laboratory tests and a visit to the Huron Road Laboratory will be conducted by Dr. Edward Siegler, director of the Department of Pathology. Dr. Siegler will also discuss prerequisites to health careers. His lecture will be presented on January 17th and 31st.

Dr. L. R. Ellick, associate director of the Department of Obstetrics and Gynecology, will speak on obstetrical problems, birth defects, prenatal sex determination, natural childbirth, abortion and family planning methods on February 14th and 28th.

Plastic and reconstructive surgery following cancer and cosmetic surgery of the face and body will be explained by Dr. Stanley Jaffe, chief of the Division of Plastic Surgery on March 14th and 28th.

Dr. N. W. Goldston, assistant clinical professor of medicine at Case Western Reserve Medical School, and a member of the Department of Internal Medicine at Huron Road, will speak on April 11th and 25th to end the series. Dr. Goldston, an expert on endocrinology, will discuss hormonal disorders, diabetes, thyroid, ovarian, and testical disorders, anemia, sickle cell disease, genetic sexual development and chromosome defects.



Continuing Education Opportunities for Physicians in Ohio

Surgical Seminars — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

Clinical Days on Emergency Care — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

Introductory Course in Nuclear Medicine for Physicians — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

November

Clean Air Symposium — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; November 10; presentations by staff and guest speakers.

Gastroenterology — Current Topics — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; November 15-16.

Hyponastremia — Causes and Management — Youngstown Hospital Association; Medical Division meeting at the South Unit, November 16, 8:00 a.m.; speaker, J. Dennis Morton, M.D., clinical instructor in medicine, Case Western Reserve University.

Scientific Basis of Newborn Care — Sponsored by the American Academy of Pediatrics, at the Shrine Burns Institute, Cincinnati, November 16-18.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Surgical Treatment of Coronary Artery Disease — Veterans Administration Center, Dayton, November 17, 2:30 to 4:30 p.m.; presentation by Charles Meckstroth, M.D., associate professor of surgery, Ohio State University; contact Hassan Mehbod, M.D., associate chief of staff at the center, 4100 W. Third St., Dayton 45428.

Symposium on Advocacy for the Mentally Retarded and Developmentally Delayed — Sponsored by OSU College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 20-21; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

December

Cardiovascular Conference — Sponsored by OSU College of Medicine, at Stouffer's University Inn, 3025 Olentangy River Rd., Columbus, December 1; contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210.

(Continued on Page 1004)

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ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Mal climacteric symptoms when these are seconlary to androgen deficiency 3. Impotence due to androgenic deficiency. 4. Postpuberal crypto chidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, suc as increased BSP retention and rises in SGOT levels, have been reporte alter Methyltestosterone. These changes appear to be related t dosage of the drug. Therefore, in the presence of any changes in live function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium an fluid retention. This may present a problem, especially in patient with compromised cardiac reserve or renal disease. In treating male for symptoms of climacteric, avoid stimulation to the point of increas ing the nervous, mental, and physical activities beyond the patient' cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or sus pected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulatio develop, discontinue therapy. In the male, prolonged administration o excessive dosage may cause inhibition of testicular function, wit resultant oligospermia and decrease in ejaculatory volume. Use caut iously in young boys to avoid premature epiphyseal closure or pre cocious sexual development. Hypersensitivity and gynecomastia ma occur rarely. PBI may be decreased in patients taking androgens Hypercalcemia may occur, particularly during therapy for metasta breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and de creased ejaculatory volume. • Hypercalcemia particularly in patient with metastic breast carcinoma. This usually indicates progression o bone metastases. • Sodium and water retention. • Priapism • Virili zation in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized as patients vary widely in requirements. Daily requirements are bes administered in divided doses. The following chart is suggested as a average daily dosage guide.

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Intensive Care Monitoring of the Seriously Ill Patient — Youngstown Hospital Association, Surgical Division meeting, at South Unit, December 2, 9:00 a.m.; speaker, Robert M. Zollinger, Jr., M.D., associate professor of surgery, Case Western Reserve University.

Current Concepts in Ophthalmology — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; December 6-7.

Endoscopic Procedures — Laparoscopy, Culdoscopy, Amnioscopy, and Fetal pH Sampling — Available to practicing gynecologists and resident staff members; December 7-8 at St. Luke's Hospital; tuition $150; registration by Nov. 30; contact Amir H. Ansari, M.D., Dept. of OB-Gyn, St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 44104.

A Day of Gastroenterology — Akron City Hospital, 525 E. Market St., Akron 44309, December 13.

January

Electrolyte and Acid-Base Therapy for the Clinician — Akron City Hospital, 525 E. Market St., Akron 44309; January 10.

Association of Physicians of the State of Ohio — Quarterly meeting and program, January 12 at the Mt. Vernon State Institute; contact Virginia S. Edwards, M.D., Secretary, 347 Lexington Ave., Mansfield 44907.

Managing the Complicated Surgical Patient — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 17-18.

Medical Aspects of Drug Addiction in Dayton — Veterans Administration Center, 4100 W. Third St., Dayton 45428; January 19, 2:30 to 4:30 p.m.; presentation by Barrett H. Bolton, M.D., director of education, Department of Internal Medicine, Miami Valley Hospital, Dayton; contact Hassan Mehbod, M.D., at the center.

Treatment of Diseases of the Esophagus — University of Cincinnati College of Medicine, January 25; contact Office of CONMED, 114 Medical College Building, Cincinnati 45219.

Gastroenterology — Ohio State University College of Medicine, January 31; contact Center for Continuing Education, 320 W. Tenth Ave., Columbus 43210.

Medical Progress for the Family Physician — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 31- February 1.

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10-10

REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1971

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1971 and the related statements of operations and net worth and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Ohio State Medical Association at December 31, 1971 and the results of its operations and changes in financial position for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Columbus, Ohio
May 24, 1972

Lybrand, Ross Bros. & Montgomery

OHIO STATE MEDICAL ASSOCIATION
BALANCE SHEET, December 31, 1971

ASSETS

Current assets:		
Cash, including time deposits of $11,514		$ 21,799
5¾% Certificate of deposit		20,000
Accounts receivable, less allowance for doubtful accounts of $15		13,441
Accrued interest receivable		343
Prepaid expenses (including $26,900 of unamortized pension costs)		35,476
Total current assets		91,059
Other assets:		
Investments:		
General Trust Fund, at cost which approximates market	$ 10,634	
Ohio Medical Indemnity, Inc., at cost (Note 3)	56,000	
Deposits	544	
Unamortized pension costs, net of current portion (Note 2)	246,500	313,678
Property and equipment, at cost (Note 1):		
Real estate	159,431	
Furniture and fixtures	59,912	
Less accumulated depreciation	(26,851)	192,492
		$597,229

LIABILITIES AND NET WORTH

Current liabilities:	
Accounts payable	$ 30,556
Deferred membership dues	71,515
Other deferred income	7,568
Total current liabilities	109,639
Net worth	487,590
	$597,229

(The accompanying notes are an integral part of the financial statements.)

OHIO STATE MEDICAL ASSOCIATION
STATEMENT OF OPERATIONS AND NET WORTH
for the year ended December 31, 1971

Income:		
Membership dues		$473,955
Exhibit fees		25,580
Annual meeting		5,875
Fees for collection of AMA dues		8,024
Interest on savings accounts and certificates of deposit		10,000
General Trust income		7,309
Other		391
		531,134
Operating expenses:		
Ohio State Medical Journal, net	$ 59,825	
Salaries	180,069	
Honorariums and expenses	50,416	
Professional conferences and scientific meetings	77,309	
Committee expenses	18,811	
Public relations	4,507	
Employee benefits, including pension costs of $26,900	42,073	
Contributions	12,024	
General operating expenses	127,307	572,341
Loss from operations		(41,207)
Net worth, beginning of year		528,797
Net worth, end of year		$487,590

(The accompanying notes are an integral part of the financial statements.)

OHIO STATE MEDICAL ASSOCIATION
STATEMENT OF CHANGES IN FINANCIAL POSITION
for the year ended December 31, 1971

Application of funds:	
Loss from operations	$ 41,207
Depreciation and amortization not requiring working capital (including $26,900 relating to pension costs)	(31,854)
Net application due to operations	9,353
Acquisition of property and equipment	151,567
Increase in General Trust Fund	7,309
Decrease in unamortized pension cost	16,400
Total application of funds and decrease in working capital	$ 184,629
Changes in the components of working capital:	
Increase (decrease) in current assets:	
Cash	$(53,173)
Certificates of deposits	(135,000)
Accounts receivable	5,969
Accrued interest receivable	(2,027)
Prepaid expenses and unamortized costs	(13,720)
	(197,951)
Increase (decrease) in current liabilities:	
Accounts payable	19,963
Deferred membership dues	(32,353)
Other deferred income	(932)
Decrease in working capital	$ 184,629

(The accompanying notes are an integral part of the financial statements.)

(Continued on Next Page)

1. In March 1971 the Association purchased one-half of the undivided interest in property located at 120 South Fourth Street, Columbus, Ohio, along with a 99-year leasehold on such property. The cost of one-half undivided interest on the property, including legal, auditing and architectural fees connected with the purchase, amounted to $21,487. The cost of the 99-year leasehold amounted to $137,944. During 1972, the Association sold such properties for $166,524.

The Association provides for depreciation over the estimated useful life of the furniture and fixtures on the straight-line and declining-balance methods. Depreciation charged to operations during 1971 amounted to $4,954.

2. The Association has a salaried employees pension plan covering substantially all employees. Such plan has been approved as a qualified plan by the Internal Revenue Service under Section 401(a) of the Internal Revenue Code. At its inception, December 31, 1969, all costs of the plan which totaled $386,900, were fully funded, and such prepaid or unamortized costs are being amortized on an actuarial basis each year. The costs applicable to 1971 operations totaled $26,900, consisting of normal costs of $5,300 and prior service costs of $21,600.

The maximum provision for 1971 of $26,900 included $5,300 normal costs and $34,200 which constitutes 10% of the frozen initial liability, reduced by interest of $12,600 on the prepaid pension cost.

The actuarially computed value of vested benefits at December 31, 1971 amounted to $314,600. The assets of the pension plan include the estimated applicable assets as actuarially computed at $169,500 plus the unamortized prepaid pension costs on the balance sheet of the Association of $273,400, totaling $442,900 as of December 31, 1971.

3. The Association owns all of the outstanding stock of Ohio Medical Indemnity, Inc., 8,000 shares, having an equity of $22,257,000 at December 31, 1971. The Board of Directors of Ohio Medical Indemnity, Inc. is prohibited from declaring or paying any cash dividends upon the common shares of the corporation. In the event of any liquidation, each common shareholder shall be paid a sum equal to the price for which such shares are issued and sold by the corporation. The remaining assets shall be distributed and transferred to the Association, or its successor organization, to be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

4. The income and expenses applicable to the operations of "The Ohio State Medical Journal" are as follows:

Income:		
Advertising (net of $11,645 commissions and $501 cash discounts)		$ 68,916
Subscriptions received from nonmembers		1,327
Membership subscriptions, allocated at $4.50 per member's dues (included in membership dues in the Statement of Operations and Net Worth)		45,900
		116,143
Expenses:		
Salaries and payroll taxes	$48,099	
Printing, postage, stationery, supplies, illustrations and engravings	75,803	
Rent, depreciation and other	6,166	130,068
Excess of expenses over income, The Ohio State Medical Journal		$ 13,925

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"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

13.8%
Do not believe combination drug products are useful.

Are combination drug product useful in treatment involvin concomitant use of two or more drugs

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, be it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription–which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to be found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin but forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tablets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and established or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a substantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I believe a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

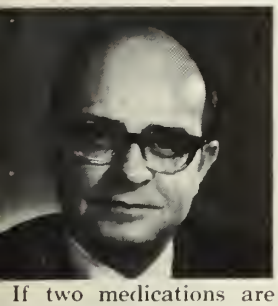
The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a great d of money. I wish we co agree on a "grandfat clause" approach to pre rations that have been in for a number of years a that have an apparen satisfactory track record

For example, I th some of the antibiotic c binations that were tal off the market by the F performed quite well. I thinking particularly penicillin - streptomy combinations that patie —especially surgical tients—were given in injection. This made less discomfort for the tient, less demand nurses' time, and fe opportunities for dos errors. To take suc preparation off the mar doesn't seem to be g medicine, unless actual age showed a great dea harm from the injecti (rather than the pro use) of the combination

The point that shoul emphasized is that th are both rational and i tional combinations. T real question is, who sho determine which is whi Obviously, the FDA m play a major role in m ing this determination. fact, I don't think it avoid taking the ultim responsibility, but it sho enlist the help of outs physicians and experts assessing the evidence in making the ultimate cision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are sed effectively to treat a ertain condition, and it is nown that they are com- atible, it clearly is useful nd convenient to provide hem in one dosage form. t would make no sense, in act it would be pedantic, o insist they always be rescribed separately. To void the appearance of edantry, the "expert" de- ries the combination be- ause it is a fixed dosage orm. When the "expert" nvokes the concept of fixed osage form he obscures he fact that single-ingre- ient pharmaceutical prep- rations are also fixed osage forms. By a singular emantic exercise he im- lies a pejorative meaning o the term "fixed dose" nly when he uses it with espect to combinations. Vhat is ignored is the sim- le fact that only in the arest of circumstances oes any physician attempt o titrate an exact thera- eutic response in his pa- ent. It is quite possible iat some aches and pains ill respond to 500 mg. of spirin yet that fact does ot militate against the *us- al* dose being 650 mg.

The other semantic ploy ften called into play is to escribe a combination roduct as rational or irra- onal.

Take antibiotic mixtures, ie source of much of the riticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

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Clinical & Scientific Features



VOLUME 68 NOVEMBER 1972 NUMBER 11

Implantation of Cardiac Pacemakers

A Review of Complications

CARL G. SCHOWENGERDT, M.D., AND MANUEL P. MASANGKAY, M.D.

PATIENTS WITH COMPLETE atrioventricular block who are managed without the use of a pacemaker show a mortality rate of 50 percent in one year. This mortality rate can be reduced to 15 percent with the use of implantable cardiac pacemakers.[1] Although the value of these units is uncontested, their use is accompanied by a significant morbidity, the degree of which is not generally appreciated. It seems worthwhile to include in one discussion a concept of the extent of complications met with these devices and a consideration of the technics which have been found helpful in minimizing these complications.

Total Morbidity Rate

Some of the complications occurring after pacemaker implantation have been directly related to the manufacture of the unit or the tissue response of the patient. This group has included insulation leaks, runaway pacemaker, premature battery failure, increase of the electrical threshold at the electrode endocardial interface, and competing ventricular rhythms. A second group has been related to the occurrence of infection, including bacteremia, endocarditis, and wound infection. A third group has been attributable to motion of the pacemaker parts, including broken leads, electrode withdrawal, electrode perforation of the ventricle, and skin erosion over the electrodes or pulse generator.

A collected review was made of those reports from 1965 to 1970, which clearly defined the complications following implantation of pacemakers with transvenous electrodes. In these reports, the unit related complications averaged 12.9 percent; the infectious complications averaged 5.2 percent; the motion complications averaged 16.6 percent; and the total complications averaged 34.7 percent (Table 1).

Those complications related to infection and motion are amenable to improvement by close attention to the technics of implantation.

Infection

Each instance of infection results in serious morbidity or mortality. The generator and electrodes usually must be removed in toto, adding the problems of cardiac dysfunction to those of major infection in a chronically ill patient. The incidence of infection is almost entirely related to the detail with which sterile technic is pursued, before, during, and after the insertion of pace-

From the Veterans Administration Hospital, Cincinnati, Ohio, and the Departments of Surgery and Medicine, University of Cincinnati College of Medicine.

Submitted March 20, 1972.

maker and electrodes. Only broad areas of failure can be identified.

One potential source of failure has been the existence of preceding infection anywhere in the body. Urinary tract infection, carious teeth, or thrombophlebitis, for example, are easily overlooked, leading to an increased incidence of sepsis or wound infection, even though the electrode manipulation and incision are remote from these contaminating sources. Another frequent source of contamination has been the entrance site of the temporary electrode. Temporary catheters are easily treated with disregard once pacing has been established; yet they constitute direct lines from the skin to the endocardium. A third area of contamination has been the fluoroscopy room used for placement of these units. Most radiology rooms have not been designed for the proper employment of aseptic technic. Scrubbing facilities are inadequate, instruments become contaminated in crowded quarters, and drapes shift with motion of the patient and the x-ray unit. As shown by Firor and his colleagues, infectious complications virtually ceased when pacemaker insertion was accomplished entirely in the operating room with the use of a portable fluoroscopy unit, as opposed to their previous 16 percent incidence of infection.[2]

The following case report is exemplary of the serious morbidity which follows inadequate control of infection during pacemaker implantation.

Case Report

This 76-year-old white man was admitted to the Cincinnati Veterans Administration Hospital on March 28, 1970 for the treatment of severe cardiac failure secondary to mitral and aortic valve insufficiency, probably rheumatic in origin. Cardiomegaly, atrial fibrillation, a ventricular rate of 40 to 60 per minute, and pulmonary congestion were present. He was treated with digitalis and diuretics, and a temporary transvenous pacemaker electrode was placed on April 9, 1970.

On April 16, 1970, a Medtronic 5841 pacemaker was implanted, using the left internal jugular vein for the electrodes and an axillary pocket for the generator. Two days later he became confused, disoriented, and oliguric. Urine culture revealed more than 10,000 *Escherichia coli.* Cardiac failure ensued on April 23, 1970, followed by a temperature of 104 F (40 C), tachypnea, mental confusion, white blood cell count (WBC) of 24,000 per cu mm, and blood urea nitrogen (BUN) rising to 145 mg per 100 ml. Blood cultures contained *E coli,* and on April 28, 1970, the generator and electrodes were removed. Generator, electrode catheter, and a subclavian intravenous line withdrawn at the same time yielded *E coli.* For the following two weeks, his survival was in question from minute to minute. He remained unresponsive to painful stimuli, required continuous respirator support, and required frequent intravenous lidocaine for the control of arrhythmias. His relatively miraculous recovery was subsequently challenged by a *Pseudomonas*-species pneumonia, an *Enterobacteriaceae*-species septicemia, and a hydrocele abscess containing *P aeruginosa.* He was discharged on July 29, 1970, alert, and without cardiac failure.

The patient again developed cardiac failure while on sodium restriction and diuretic treatment, and was readmitted on September 19, 1970, for placement of a cardiac pacemaker. Thorough preoperative evaluation revealed a urinary tract infection due to an α-hemolytic streptococcus, *Klebsiella pneumoniae,* and *E coli.* He was treated appropriately, discharged, and readmitted on November 30, 1970. At this time no infection was identified. A Medtronic 5841 pacemaker was implanted on December 7, 1970, using the right internal jugular vein for the electrode catheter and an axillary pocket for the generator. His postoperative recovery was uncomplicated.

Table 1. Collected Incidence of Complications in Transvenous Pacemaker Implantations, 1965-1970.

Author	No. of Patients	Complications		
		Infectious	Motion	Total
Center	102	0	16	27
Davies	33	1	0	3
Edhag	260	22	61	132
Forbes	44	0	20	20
Furman	115	14	7	21
Gadboys	99	2	18	20
Harthorne	130	1	15	56
Leininger	22	—	0	—
McLaughlin	25	1	3	6
Norman	20	1	2	3
Smyth	28	—	0	—
Spencer	22	1	6	7
Williams	37	3	8	13
	937	46/887	156/937	308/887
		5.2%	16.6%	34.7%

The original sepsis in this patient could have stemmed from the subclavian catheter, the temporary pacemaker catheter, or the permanent pacemaker catheter. It is probable, however, that it originated from an unrecognized urinary tract infection. Had this preexisting infection been recognized and treated, it is likely that none of the above life-threatening complications would have occurred.

Motion Complications

In review of those complications following pacemaker implantation which relate to broken catheters, electrode withdrawal or displacement, perforation of the right ventricle, erosion over electrode catheter, or dehiscence of the generator pocket, it appears clear that any means of reducing

The Authors

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motion of the pacemaker parts will reduce the complications which have occurred. Certain technics have been found of value for immobilization of the generator and proximal electrode catheter.

Early use of the abdominal wall for the generator pocket produced a high incidence of motion complications, most of them related to broken electrode wires. In the series reported by Lillehei and co-workers, for example, the incidence of motion complications was 37 percent.[3] This experience prompted the widespread use of the prepectoral pocket for the generator. In those series from 1965 to 1970, in which only prepectoral pockets were used, the average incidence of motion complications was 13 percent.[4-11] Further decrease in motion complications has been obtained by use of an axillary or deep pectoral pocket, sitting against the more immobile chest wall. In the cases of Davies and Siddons,[12] and McLaughlin and colleagues,[13] in which only axillary pockets were used for the generator, the average incidence of motion complications was 5.2 percent.

Placement of the electrode catheter in the most immobile position obtainable has also decreased the incidence of motion complications. Leininger and Neville stressed use of the centrally positioned, relatively fixed jugular vein for entrance of the catheter.[8] McLaughlin and colleagues recommended exit of the catheter posterior to the sternocleidomastoid muscle,[13] and Smyth and Bacos stressed leading the catheter over the medial head of the clavicle,[10] both to avoid transmitted motion from the clavicle. Placement of the catheter tract posterior to the pectoralis major muscle, leading to a deep pectoral or axillary pouch, results in less transmitted motion than that obtained from an anterior tunnel to a prepectoral pouch. Use of the nondominant side, if it is available, further decreases upper extremity motion transmitted to the pacemaker.

The following case report illustrates the complications which can result from motion of the pacemaker parts.

Case Report

A 54-year-old, right-handed postal supervisor sustained a myocardial infarction in December 1967, with resulting 2:1 heart block. Complete heart block accompanied by dyspnea on exertion had developed by March 1968.

In April 1968, a Medtronic 5841 pacemaker was implanted, using the right external jugular vein for the catheter electrode and a prepectoral pocket for the pulse generator. His cardiopulmonary symptoms were completely relieved, although he did on occasion have intermittent contraction of the diaphragm and abdominal wall muscles. He continued a very active life, playing golf, pitching horseshoes, and breaking rocks with a sledgehammer. By March 1969, the pectoral pocket was swollen, and the overlying skin was erythematous, tight, and shining. A chest x-ray film demonstrated withdrawal of the endocardial electrode, sharp angulation at the vein entrance site, and caudad migration of the generator. Under local anesthesia the pocket was re-formed over the battery, using thick flaps of fresh tissue. No bacteria were cultured from the wound. By June 1969, the pectoral pocket was again tender and bulging with fluid, with a wide, transparent scar laterally. On July 2, 1969, a right axillary pocket was formed, with the intention of moving the pulse generator entirely away from the pectoral area. Pacing, however, was found to be intermittent, and fluid from the pectoral pocket was found to contain bacteria (*Staphylococcus aureus* on subsequent report). A temporary transvenous electrode was inserted from the left brachial vein and the generator of the permanent pacemaker removed. On July 17, 1969, a Medtronic epicardial electrode (5814) was placed transthoracically, using a left axillary pocket for the pulse generator (Medtronic 5841). The previously placed transvenous electrodes were removed later without difficulty.

The patient has continued to lead a highly active life without any further problems related to his pacemaker, and he is delighted with the present result. His complicated course could perhaps have been avoided by a different initial choice of sites. Had the nondominant side, internal jugular vein, and an axillary pocket been used for the initial implantation, he might have escaped further difficulty. Moreover, there are certain patients, usually young and active, who are better served initially with an epicardial transthoracic electrode. This patient is one who might have benefited from an initial transthoracic approach.

Summary

A collected review of the experience from 1965 to 1970 discloses an average 5.2 percent incidence of wound infection and sepsis in those series of implanted cardiac pacemakers with transvenous electrodes, in which the authors clearly delineated these complications. Major areas in which contamination occurred include unrecognized preceding infection, the negligent care of temporary electrodes, and the fluoroscopic facilities available for implantation.

The incidence of motion complications, including broken leads, loss of electrode position, ventricular perforation, and erosion over the generator or wires, averaged 16.6 percent in those reports of implanted units with transvenous electrodes which clearly delineated these problems. These complications are minimized by the use of the nondominant side, the internal jugular vein, an electrode catheter tract over the medial head of the clavicle and posterior to the pectoralis major muscle, and by the use of a deep pectoral or axillary pocket for the pulse generator.

Using only those reports published from 1965 to 1970 which clearly defined their technics and complications, the incidence of all significant complications attending the implantation of cardiac pacemakers with transvenous electrodes averaged 34.7 percent.

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

This 50-year-old man enters your office with the history of a gradual swelling located at the superior medial aspect of his right orbit (Fig. 1). He has no nasal symptoms, nor does he complain of headaches. He has no visual symptoms. Upon palpation there is a firm but compressible mass beneath the skin which feels much like a ping-pong ball.

What is your diagnosis, and how could he be further evaluated and treated?

(See p. 1040 of this issue for further information and discussion.)

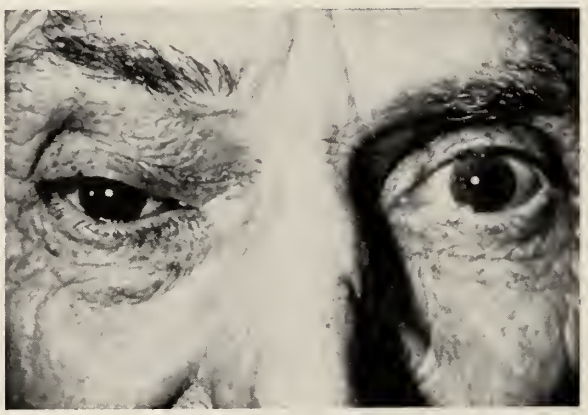


Fig. 1. Note mass located at superior medial aspect of right orbit.

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Ruptured Appendicitis

Three Case Reports of an Unusual Complication

Jerome H. Meyer, M.D.

THAT THE VERIFORM APPENDIX, with its diseases and complications, is still a challenge that can be attested to by the fact that 262 articles were published about this subject in 1970.[1]

Three patients with unusual complications of a ruptured appendicitis are herein presented. All three had similar signs and symptoms and physical findings which we feel are worthy of presentation and recording.

Case Reports

Case 1. This 46-year-old white, male physician entered the hospital on May 14, 1965, with the complaint of fever and pain in his right hip. Two weeks prior to admission, he had some generalized abdominal pain which lasted two days and left him. He stated that he did have some pain in his right lower side in retrospect, but it did not impress him. He had no loss of appetite, nausea, or vomiting. His most predominant symptom was, by far, the pain in his right hip joint, which became progressively worse until he was unable to extend his leg at the hip joint without severe pain. Several injections of steroids were given in his right hip. His temperature varied but remained elevated and reached 101 F (38.3 C) to 103 F (39.4 C) each night. A thorough investigation to determine the cause of fever and the pain in the hip was accomplished without finding the cause.

Surgical consultation was requested on May 23, the ninth hospital day. Examination at that time revealed three notable findings: first was the flexion of the patient's right leg at the hip which could not be extended without severe pain; his abdominal findings were insignificant; but the right costovertebral area was extremely tender to percussion.

Review of the flat plate of the abdomen, taken May 19, 1965, showed "a vague amount of increased density superimposing the midflank area on the right side. This is in the area of the right psoas muscle not shown."

The diagnosis of a right-sided retroperitoneal abscess, possibly due to a ruptured appendix, was made, and his abdomen was explored the same day (May 23, 1965). A ruptured appendix was removed and an abscess the size of the surgeon's fist was found in the psoas muscle and was drained. Most of the necrotic tissue was removed.

His most remarkable improvement occurred the next morning, with a complete loss of pain in the right hip and return of a full range of motion of the hip joint. His recovery was uneventful, and he was discharged on the ninth postoperative day. His temperature was normal after the fourth postoperative day. The pathologist's report confirmed the diagnosis of the ruptured appendix with abscess formation. Culture from the abscess revealed *Escherichia coli.*

Case 2. This 67-year-old, white woman was admitted to the hospital on January 23, 1970, with abdominal pain which had been present in the right lower quadrant for two weeks. She was bedridden at home for about ten days and complained of pain in the right hip joint and loose stools without blood. She refused to allow extension of her flexed right hip.

Past history and family history were not obtainable from the patient, as she would not answer these questions. She lived alone but kept some boarders in her home. Her companion gave us most of the history. Her appetite was poor, but she ate something each mealtime. Her stools were watery.

On physical examination, her temperature was 101 F (38.3 C); pulse rate 120 beats per minute; respiratory rate 25; and blood pressure was 102/50 mm Hg. She was markedly dehydrated.

Positive findings included tenderness in the right iliac fossa, the right inguinal region, and the right femoral area. Her right leg was flexed at the hip, and even slight motion was painful. There was a questionable

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FIG. 1. Note radiographic solution around lesser and greater trochanter of right femur.

mass in the right lower quadrant of the abdomen. The diagnosis of ruptured appendicitis was made.

White blood cell count (WBC) showed 9,666 per cu mm total neutrophils, with 59 percent leucocytes, 24 stabs, 12 lymphocytes, and 5 monocytes. It was decided to delay surgery for better localization and for better preparation of the patient.

She was prepared for surgery with fluids and electrolytes, and antibiotics were given. On January 28, 1970, an abscess began to localize in her right upper thigh, and on February 4, the abscess was incised and drained. It seemed to come from the pelvic region. A straight catheter was sutured in the abscess. Her temperature improved rapidly. Renografin was injected to determine the size and the possibility of connection with the pelvis (Fig. 1). She was taken to surgery on February 24, and the ruptured appendix was removed and the abscess drained. Her recovery was uneventful and the range of motion of her hip improved. She was discharged on the 19th postoperative day.

Case 3. This 86-year-old, white man was seen in his family physician's office ten days prior to admission to the hospital, complaining of pain in his right hip. He was thought to have bursitis of the right hip joint. Treatment consisted of 40 units of ACTH. Three days later, he returned to his physician's office and reported dramatic improvement. The ACTH treatment was repeated.

The next day, the patient was seen at his home, again complaining of the same type pain. He was afebrile, and in addition to his complaint of hip pain, he had some tenderness of the right lower abdominal quadrant. Rectal examination was negative. He was urged to sub-



FIG. 2. Note gas around lesser trochanter of right femur.

mit to hospitalization but he refused. On the third day prior to admission, he was seen again and he again refused hospitalization. He did submit to an x-ray study of his right hip, which was reported as normal.

The patient presented himself in the emergency room on March 10, 1968, the day of admission to the hospital. He appeared toxic. His temperature was 102 F (38.9 C). There was tenderness of the right hip and severe tenderness of the right lower abdominal quadrant.

Of the blood chemistries studied, the only abnormalities were blood urea nitrogen (BUN) of 80 mg per 100 ml, and potassium 5.8 mEq/liter. His hemoglobin level was 14.4 gm per 100 ml; hematocrit reading was 44 percent; total WBC was 16,400. The differential count revealed 32 percent neutrophils, one stab, 65 percent lymphocytes, and 2 percent monocytes.

X-ray studies of the right hip (Fig. 2) and pelvis were reported as follows: "Examination of the pelvis and right femur reveals gas in the soft tissue about the femur, most marked in the region of the lesser trochanter." He was treated with intravenous fluids and antibiotics and was taken to surgery. A psoas abscess, secondary to perforation of a retrocecal appendix, was found and was drained of pus. The necrotic appendix was removed and the abdomen drained.

The pathology report revealed a mucinous adenocarcinoma of the appendix with necrosis. He was treated with antibiotics and supportive therapy but he died on the first postoperative day. A culture of the abscess was later reported to yield *Escherichia coli* and *Streptococcus faecalis* organisms. Postmortem examination revealed the psoas abscess "with tracking downward beneath the inguinal ligament into the region of the right hip."

Discussion

It is well known that the acutely inflamed appendix causes referring symptoms of every organ it contacts; small bowel, colon, urinary bladder, kidney, and ureter.[2]

It is not the purpose of this paper to discuss the diagnosis and treatment of acute appendicitis and its complications. The three cases herein presented show the common findings of fever and severe pain in the right hip joint, which were the predominant presenting symptoms. The abdominal signs and symptoms seemed to be secondary and insignificant.

These three cases further emphasize the need of a careful and thorough probing for an accurate history. The ruptured appendix, confined to the retroperitoneal space, can cause referred pain to the hip joint as well as psoas abscess and the extension of the abscess out of the pelvis, through the femoral area to the hip joint and thigh.

Summary

Three cases with an unusual complication of ruptured appendix are reported. Each of the three cases presented similar predominant symptoms of fever and severe pain in the right hip. Evidence is documented that a confined retrocecal appendiceal abscess can dissect into the psoas muscle and then descend into and along the psoas muscle to the right hip, and under the inguinal ligament into the thigh.

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MEDICAL SECRETARIES like to belong to a service team, to be personally involved in group loyalties, to get away from time to time from the shorthand and typing routine, to feel they are giving personal service to all the patients who ring for advice.

Hospital work undoubtedly possesses glamor for the young entrant, and most prefer to start there, but many secretaries work for and with consultants and general practitioners. The consultant does not need to be told how important a colleague his secretary is: she can make or mar a practice. If patients are alienated, reports sent to wrong destinations, or appointments upset, incalculable harm may be done. On the other hand, a Harley Street gynecologist used to say that "many of my patients need only a talk with my sympathetic secretary, and not treatment from me."

The secretary in general practice, especially in the country, will find her desire for involvement with other people entirely fulfilled. She will know many of the patients socially and also have access to confidential information about them, so her discretion and good sense must be undoubted. The amount she sees of the patients varies; if she is also the receptionist, she will know them all face to face; if not, she may see the world in a mirror through the letters and notes that go through her hands. — *British Medical Journal,* Colleagues in Health Care, 4:676-677, Dec. 11, 1971.

Ocular Toxicity of Systemic Drugs

A Review of the Effects of Seven Commonly Used Agents

Frederick H. Davidorf, M.D.

As new drugs are developed, their toxic side effects are becoming increasingly important. The practitioner is not only expected to watch for the known toxic effects of medicines, but he must be alert to adverse effects of new drugs. Many of the adverse effects have been discovered after the drug has been on the market for several years. The subject of drug toxicity is a broad one and a comprehensive study would require volumes. Ophthalmologists frequently see patients in whom systemic medications have caused irreversible ocular damage. It is important for the physician to acquaint himself with these possible side effects so that the drug can be discontinued before permanent damage has occurred. The purpose of this paper is to present some of the more commonly seen ocular reactions or side effects to systemic medication. The toxicities of chloroquine (Aralen), chlorpromazine (Thorazine), thioridazine (Mellaril), the oral contraceptives, the corticosteroids, indomethacin (Indocin), and chloramphenicol (Chloromycetin) will be presented.

Chloroquine

Chloroquine (Aralen) was developed in the early 1940's as an antimalarial drug. This has continued to be the drug of choice in the prevention and treatment of malaria. The toxicity to the retina was first described in 1959.[1] Since that time, over 200 papers on various aspects of the toxicity of the drug have been written. To complicate matters, chloroquine has been found to be useful in the treatment of various other chronic diseases, such as rheumatoid arthritis and lupus erythematosis. Hydroxychloroquine (Plaquenil) has been used in a manner similar to that of chloroquine. It is tolerated at higher dosages but its therapeutic and toxicologic aspects are quite similar to those of chloroquine.

Chloroquine affects the cornea, ciliary body, and lens, as well as the retina.

Cornea: Chloroquine keratopathy is limited mainly to the corneal epithelium. Clinically, the pattern of deposit varies from a diffuse haze to an aggregation of radial and whirling lines converging and coalescing on a zone just beneath the center.

Less than 50 percent of the patients with corneal changes exhibit symptoms. If symptomatic, the common complaints are halos around lights and photophobia. There is usually no decrease in visual acuity. The corneal changes are fairly common, occurring in 30 to 70 percent of patients on therapy.[2] Similar effects are noted with hydroxychloroquine. The incidence of corneal changes is dose-related. There is more frequent and extensive involvement with increasing duration of administration and total dosage. These corneal deposits may appear as early as two to three weeks after the drug is started and the changes disappear completely after the drug is discontinued. Therefore,

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the presence of corneal change is not an indication to discontinue chloroquine therapy. If the visual symptoms become too severe, the drug obviously should be discontinued.

Ciliary Body: The muscles in the ciliary body are affected in patients who receive chloroquine for extended periods. The patients commonly complain of difficulty focusing on objects. The complaints start soon after the onset of administration and are reversible when the dosage level is reduced.

Lens: One should be aware of the tiny, white, flake-like lenticular opacities which have been observed in patients on chloroquine therapy. These do not resemble steroid-induced cataracts, which are posterior subcapsular opacities.

Retina: There is a wide variation in the clinical appearance of the macula. The basic change is that of a pigmentary disturbance or alteration in the background pigmentation of the macular area. The amount of involvement depends upon the length of time the chloroquine was continued after the damage had begun.

The earliest sign is that of a mild pigment disturbance of the macula, or a loss of the foveal reflex. At this stage, if there is no central scotoma, there is a fairly good chance that the pigmentary disturbance will be reversible upon discontinuance of the drug.

If the chloroquine is continued, the pigment changes can remain quite subtle or they may show additional progression to the characteristic bull's-eye appearance. There is never any sign of inflammation, hemorrhage, or exudates!

The classical "bull's-eye" or "donut" appearance does develop in a number of patients. This consists of central pigment clumping. Immediately adjacent is a pigment-free zone and then there is an outer pigment ring. One must realize that this characteristic appearance is not always present.

The subject of chloroquine toxicity is important to us all in relation to our involvement in Southeast Asia. Chloroquine and primaquine are the drugs of choice for the prophylaxis and treatment of malaria. All military personnel who go to South Vietnam are required to continue the medication for two months after returning to the United States. The dosage for prophylaxis is 500 mg of chloroquine and 80 mg of primaquine taken weekly. If an individual contracts malaria, the treatment is from 500 to 1000 mg of chloroquine immediately, then 500 mg daily for two to three days. After this, the dosage reverts to the weekly level. There have been well over one million servicemen who have been on chloroquine for antimalarial prophylaxis, and there are no reported cases of ocular toxicities when the drug was taken at this level!

The patients who are taking chloroquine for diseases such as lupus erythematosus and rheumatoid arthritis need higher levels of chloroquine to control the disease. These are the individuals who must be watched carefully for the signs of drug toxicity.

There have been 300 cases of chloroquine retinopathy reported in the world literature. There seems to be a clear relationship between the incidence, daily dosage, total dosage, and duration of therapy in the development of chloroquine retinopathy. The incidence of retinopathy is near zero if the dosage is kept under 250 mg per day, even when given for long periods of time.[3,4]

Chlorpromazine

Another important drug with ocular side effects is chlorpromazine (Thorazine). Since 1953, it has been used as a tranquilizer and a psychotropic agent in an estimated 50 million patients. The usual dosage is 75 to 2000 mg per day, depending upon the severity of the mental disorder. Ocular abnormalities were not noted until 1963, almost ten years after the introduction of the drug.[5] Most systemic side effects of chlorpromazine occur within the first three months of treatment and are not dose-related. The more common oculogyric crises usually will occur within the first week of treatment, after a single dose, or after a sudden increase over the previous dose. Another common reversible reaction is a light-related sunburn that occurs in about 25 percent of these patients on high dosage regimens.[5]

Associated with the skin pigmentation is a grayish-brown pigmentation of the bulbar conjunctiva in the exposed interpalpebral area. The limited distribution of both the skin and conjunctival pigmentation clearly indicates its relationship to light exposure. There is moderate deposition of yellow pigment granules in the conjunctival stroma.

Cornea: The corneal changes consist of white-to-gray granular opacities which appear initially in the superficial cornea. On higher dosage levels, the deeper layers of the cornea become involved.

Lens: The lens opacities begin as a brown dust-like pigmentation on the anterior capsule, just beneath the anterior surface of the lens in the pupillary area. During therapy, the brown coloration disappears and gray-white or yellow discrete granules develop. These granules initially cover an area of two square millimeters. They may progress peripherally in a stellate appearance to form a

true anterior polar cataract, which can increase in size in spite of cessation of therapy.

Conjunctiva and Skin: Skin and conjunctival pigmentation is most commonly seen in patients who have received very high doses, such as 1000 to 2500 mg per day. At this dosage level, the pigmentation can appear within a few months. It may be seen, however, on lower dosage levels but for longer periods of time, so that total dosage may be a factor.

The corneal and lens changes appear to be dose-related. At a daily dosage greater than 300 mg for more than three or four years, one might expect a 30 percent incidence of lens abnormalities and a 17 percent incidence of corneal changes. When the total dosage reaches 1500 to 2000 mg, the incidence of both corneal and lens changes can be as high as 80 percent to 90 percent. A daily dosage of 200 mg or less could probably be continued indefinitely with minimal chance of producing ocular abnormalities.[5]

Retina: Chlorpromazine has a strong affinity for melanin pigment and is found in high concentrations in the uveal tract and pigment epithelium of the eye. In spite of the very high chlorpromazine level lying adjacent to the retina, there is little evidence of a retinal toxic effect such as has occurred with other phenothiazines and chloroquine. Only six cases of pigmentary retinal disturbance have been reported in the literature.

Ideally, patients should have an ocular examination prior to chlorpromazine therapy. Patients receiving chlorpromazine therapy for more than two years and at greater dosages than 300 mg per day should be re-examined at six-month intervals. If only corneal and lens opacities are present and vision is not impaired, chlorpromazine could be continued. If skin or retinal pigmentation occur, or if an unexplained visual disturbance is observed, the dosage should be decreased to below 400 mg per day if possible.

Thioridazine (Mellaril)

Thioridazine is another phenothiazine drug of importance to us. As with the other phenothiazines, thioridazine is accumulated in the choroid and retina.[6]

Thioridazine is a very effective psychotherapeutic drug which is widely used today. The initial complaints are those of blurred vision and decreased night vision. Ophthalmoscopic changes consist of engorgement of the retinal veins and hyperemia of the disc. Within two or three weeks, fine pepper-like pigment spots appear throughout the entire fundus. With the passage of time, the pigment begins to coalesce and form larger clumps. This disturbance primarily involves the pigment epithelium. The degree of involvement and visual impairment is dose-related. In a study of 60 patients treated with thioridazine, no patients receiving maximum daily doses of less than 1000 mg showed any pigment retinopathy or visual impairment, but 9 out of 12 patients receiving 1200 to 2100 mg daily had pigmentary retinopathy.[7] Currently, the recommended daily dose is below 800 mg per day, which should be low enough to prevent retinal toxicity.

Oral Contraceptives

In April 1965, an editorial in the *Archives of Ophthalmology*[8] drew attention to certain neuro-ophthalmologic conditions that had occurred in patients on oral contraceptives and suggested that ophthalmologists who see and suspect a relationship between oral contraceptives and ocular disease report their findings to Dr. Frank Walsh. In November 1965, Dr. Walsh and co-workers reported on 63 patients from the United States, Australia, and Canada.[9] Ocular abnormalities were found in 21 patients and included retinal vein thrombosis, retinal artery branch thrombosis, optic neuritis, ocular nerve palsy, unilateral exophthalmos, perivasculitis, vitreous hemorrhage, and macular abnormalities. Of the remaining patients, there were four cases of pseudotumor cerebri, 17 cases of stroke syndrome, and 10 cases of migraine. This report certainly did not constitute a definite proof of a casual relationship between the oral contraceptives and the mentioned ocular abnormalities. At that time, there were an estimated five million women taking birth control pills. The question as to whether there was a greater incidence of neuro-ophthalmologic abnormalities in this group when compared to a similar group of women not taking oral contraceptives could not be answered.

Several studies were undertaken to resolve this question. One study did not reveal any significant ocular abnormalities in over 200 patients who had taken the medication from one to three years. Another group studied 300 women before therapy and again one to three years after therapy was started. No neuro-ophthalmologic or retinal vascular disturbances were found during treatment.[10] The current medical opinion regarding ocular adverse effects is that a causal association cannot be confirmed. This is in contrast to the fact that a statistically significant association has been demonstrated between the use of oral contraceptives and thrombophlebitis, pulmonary embolism, and cerebrovascular accidents.[9]

Even though there is no evidence to support an association with these ocular abnormalities, it would be wise in the routine examinations of these patients to make a special note of any abnormalities in the fundi and certainly of any history of

retrobulbar neuritis or migraine. If any serious ocular abnormality occurs, the patient should be advised to discontinue the oral contraceptives.

Corticosteroids

The anti-inflammatory effect of corticosteroids is most useful to the physician. These drugs are the mainstay in the treatment of many medical conditions.

There was a ten-year delay between the introduction of cortisone and the awareness that the corticosteroids can produce the picture of chronic simple glaucoma. The studies on the long-term use of topical steroids have unequivocally shown a causal relationship. There have also been several studies trying to determine the relationship between systemic corticosteroid therapy and glaucoma. Forty-eight patients under treatment for various auto-immune diseases were studied. Systemic or topical corticosteroid therapy was found to cause increase of intraocular pressure. This is usually completely reversible within a month's time.[11] The possibility of pressure elevation should be considered in all patients receiving long-term corticosteroid therapy. With appropriate precautions, this side effect can be detected early so that permanent visual loss does not occur.

Posterior subcapsular cataract formation has been reported as a complication of long-term high dosage systemic corticosteroid therapy. In one report, 72 patients receiving long-term steroid therapy and 23 control patients with rheumatoid arthritis not treated by steroids were studied. Posterior subcapsular cataracts were found in no patients receiving steroids for less than one year. Cataracts were found in 42 percent of patients treated for one to three years and in 58 percent of those treated for four years or more. The incidence of cataract formation was closely related to steroid dosage. Only 11 percent of patients receiving less than 10 mg daily of prednisone developed cataract in comparison with 30 percent receiving 10 to 15 mg daily and 80 percent receiving more than 15 mg per day. Most of these cataracts, however, were clinically insignificant in that they did not interfere with vision.[12] The dosage and duration of systemic corticosteroid administration appear to be the primary determining factors in the production of posterior subcapsular cataracts. Many of the people being treated with long-term corticosteroid therapy have rheumatoid arthritis. It should be recognized that patients with this disease not receiving corticosteroid therapy have an unusually high incidence of posterior subcapsular cataract. When one considers the cataract formation in any given individual, it is most difficult to ascribe a definite cause-and-effect relationship between the steroid treatment and cataract formation. "Corticosteroid therapy is here to stay, for use where indicated. It is a two-edged sword however, and can cause serious complications and side effects if it is used unwisely."[13]

Indomethacin

Indomethacin (Indocin) is an anti-inflammatory analgesic and antipyretic drug for the symptomatic long-term treatment of rheumatoid arthritis, osteoarthritis, and gout, used in dosages up to 200 mg per day.

In one study, retinal lesions similar to those produced by chloroquine were observed in 15 of 34 patients examined who were on long-term indomethacin therapy. There was a pigmentary disturbance and atrophy in the macula. In some cases, a diffuse retinal disturbance was present, characterized by a granular appearance of the fundus, waxy disc, depressed electroretinogram, and constricted visual field.[14]

Studies done at The Ohio State University have not substantiated the findings of Dr. Charolet H. Burns. Drs. Rothermich and Magnuson studied a total of 170 patients taking indomethacin. According to an oral communication from Dr. Magnuson in October 1971, these patients were taking daily doses of 50 to 150 mg for from one to five years. They had complete ophthalmologic examinations at 18- to 24-month intervals. This group of patients was compared to a group of 160 patients not taking the drug. There was no evidence of pigmentary macular changes in either group. Sixteen patients had dark adaptation curves which were normal. Four of these patients had the adaptation curves done both before treatment and while on treatment and there was no significant change. In our experience, indomethacin at daily doses of 50 to 150 mg given over a period of from one to five years appears to have no toxic ocular side effects.

Chloramphenicol

Chloramphenicol was introduced in 1948 as a broad spectrum antibiotic. It is felt that it can produce optic neuritis or papillitis after relatively long-term use at high-dose levels.

Since 1952, a total of 32 cases have been reported. The majority were in children with cystic fibrosis in whom large daily doses, an average of 1 gm per day, have been given for periods up to two years.[15,16]

Peripheral neuritis, characterized by numbness and severe cramps of the feet and toes, frequently follows the visual complaints by one to two weeks. Acute bilateral loss of visual acuity occurs along with papilledema, a central scotoma, and peripheral field constriction. Optic atrophy is

Table 1. Ocular Effects of Systemic Medications

	Conjunctiva	Cornea	Lens	Ciliary Body	Retina and Choroid	Optic Nerve	Glaucoma
Chloroquine	No	Yes	Yes	Yes	Yes	No	No
Chlorpromazine	Yes	Yes	Yes	No	Yes	No	No
Thioridazine	No	No	No	No	Yes	No	No
Oral contraceptives	No	No	No	No	?	?	No
Corticosteroids	No	No	Yes	No	No	No	Yes
Indomethacin	No	No	No	No	Yes (?)	No	No
Chloramphenacol	No	No	No	No	No	Yes	No

a late sign. The prognosis is quite variable, and improvement, if it does occur, is independent of whether the drug is continued or discontinued. Permanent visual loss frequently results and the drug should not be reintroduced, except as a life-saving measure. It is recommended that a patient starting on long-term chloramphenicol treatment receive a baseline ophthalmologic examination.

Conclusion and Summary

Some of the known ocular toxicities to systemically administered drugs have been presented (Table 1). The most productive modality to detect early changes is careful ophthalmologic examination including visual acuity, visual fields, slit lamp, and fundus examination.

The practitioner must have a high index of suspicion in patients with unexplained ocular disease to diagnose a toxic drug reaction. Obviously, a history of drug ingestion must be obtained before the diagnosis of drug toxicity can be confirmed. The tragic story of thalidamide causing the malformed children is fresh in our memories. Many remember MER-29 or triparanol that caused cataracts in many unfortunate individuals. As physicians, it is our obligation to protect our patients against the toxic effects of medicines. We must be suspicious of all new systemic drugs; patients receiving new drugs for prolonged intervals should undergo periodic, thorough eye examinations.

Generic and Trade Names of Drugs

Chloroquine — Aralen (Winthrop Laboratories)
Chlorpromazine — Thorazine (Smith, Kline & French Laboratories)
Thioridazine — Mellaril (Sandoz Pharmaceuticals)
Indomethacin — Indocin (Merck Sharp & Dohme)
Chloramphenicol — Chloromycetin (Parke, Davis & Company)
Hydroxychloroquine — Plaquenil (Winthrop Laboratories)

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Multiple Ureteral Diverticula

Case Report with a Discussion of Etiology

Jack L. Summers, M.D.; Walter A. Keitzer, M.D.; and Thomas R. Hathaway, M.D.

MULTIPLE URETERAL DIVERTICULA are rare. A total of 18 cases have been reported previously.[1-8] This case represents the 19th case reported.

Case Report

A 66-year-old white man was admitted to Akron City Hospital on July 12, 1971, with the chief complaint of a steadily decreasing urinary stream. He voided small, frequent amounts and had nocturia and dysuria. He had a long history of urethral stricture, had undergone frequent dilatations in the office, and had suffered multiple recurrent infections.

Findings on physical examinations were entirely within normal limits.

Blood urea nitrogen, complete blood cell count, and SMA-12 were normal. The urine contained 15 to 20 white blood cells per high power field. No organism could be cultured from the urine.

The patient underwent cystoscopy, anterior urethrotomy with the Otis urethrotome to 35 French, and the bladder neck was incised down to the capsular fibers by the Keitzer-Cervantes cold-knife technic. Retrograde pyelograms taken at surgery are shown in Figure 1. Intravenous pyelograph (IVP) done one month before in the office had shown no evidence of the diverticula. A 28-French Teflon catheter was left indwelling after the procedure.

The recovery period was unremarkable, and the patient was discharged five days later with the Teflon catheter still indwelling. One month later the catheter was removed in the office, and the patient's urethra easily accepted a 28-French steel sound. Subsequently, he has had a good stream, no residual, and has been free from infection.

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Discussion

Bothe and Cristol[9] have shown that 15 percent of the people with urinary tract infection have microscopic evidence of cystic changes in the ureters. It seems strange that clinical evidence of diverticula are so rarely seen; or as may be the case, the disease may be frequently seen, but rarely reported.

Culp[10] feels that a muscular layer is missing from the ureter in cases of acquired diverticula. The actual anatomy of multiple ureteral diverticula has never been studied, since none of these cases has come to autopsy.

Another distinct possibility, more in keeping with modern anatomic concepts of the ureter, could explain the diverticula formation. It is a well-accepted fact that back pressure of the ureters from distal obstruction causes dilatation and hypertrophy of the ureteral lumen and musculature. Perhaps these diverticula are out-pouching of the ureteral mucosa through a defect be-

tween the hypertrophied and dilated ureteral musculature, as seen in the bladder's response to obstruction of outflow, by cellule and diverticulum formation.

All reported cases of multiple ureteral diverticulosis carry the common denominators of infection and distal obstruction, as did our patient. This would seem to add further credence to this postulate. The fact that the lesion could not be demonstrated on IVP and was found on retrograde examination almost certainly implicates back pressure in the etiology.

The presence of these diverticula appear to carry no adverse effect on the course or prognosis of the patient. They are a radiologic and anatomic curiosity that are the effect of a pathologic process and not a pathologic entity, in themselves. They should be recognized as such, and the patient should be spared unnecessary examinations and procedures. Treatment should be that of the obstructive disease. If, however, these diverticula are seen on a routine study, in an asymptomatic patient, a thorough search must be made for the underlying infection and distal obstruction.

Summary

The 19th case of multiple ureteral diverticulosis is reported. The connection between distal obstruction and infection as etiologic precipitants is emphasized. A new proposed etiology for this disorder is discussed, in which back pressure causes the ureteral musculature to hypertrophy and dilate, with herniation or ureteral mucosa. It is urged that the findings of multiple ureteral diverticulosis be recognized as a resultant of the pathologic process of distal outflow obstruction, and not as a disease entity in and of itself.

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FIG. 1. Retrograde pyelogram showing multiple ureteral diverticula.

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Routine Bedside Use of the 'Elgustometer'

Suggestions for Greater Portability with a Summary of a Small Series of Cases

Donald M. Posner, M.D.

THE INADEQUACIES of testing taste by the use of solutions representing sweet, salt, sour, and bitter qualities have long been known. Standardization of the solutions as to their concentration, the amount placed on the tongue, the position of the solution on the tongue, and the interval between testing with different solutions in the same patient has been ill-defined, or at best, arbitrary. When the solutions are too highly concentrated, one runs the risk of stimulating the fifth cranial nerve rather than the seventh (or ninth). At best, the results are but semi-quantitative. The method is technically clumsy, and, consequently, is often omitted during the course of routine neurologic examination. Textbooks of neurology have on occasion fleetingly pointed out these deficiencies and concomitantly mentioned electrical taste testing without going into any further detail.[1,2]

In 1958, Krarup described an apparatus of his design for use in the determination of taste thresholds (electrogustometry).[3] The following year, he further described the clinical applicability of his method.[4] The full details of the construction of this machine, the theory behind its use, and its method of application can be found in the original work.

In brief, this apparatus (called an "Elgustometer" by its inventor) uses a current range up to 300 microamperes, divided in 37 units distributed logarithmically and called Electric Gust Units (EGU.) The technic suggested, and followed in the cases presented herein, is a method of descending and ascending stimulations alternating with contacts of the electrode with the tongue in which no stimulus is applied. A supraliminal stimulus is initially employed and then the amperage is decreased stepwise. At each new level of current intensity, double application of the electrode to the tongue is performed. During one of these two applications, no stimulating current is actually used. At any individual current level, the patient is asked if he can detect a difference between the two applications. If he can do so, he is presumed to be detecting the stimulus at that level.

The "Elgustometer" as originally described was rather too large and cumbersome to be carried in a physician's bag and used in routine bedside testing. Thus, in its inconvenience, it seemed to have a fault in common with the classical method using solutions. The machine used in connection with the cases herein reported was an attempt at a small, inexpensive version of the original (Fig. 1). Electrically, the two machines are quite similar. Battery operation, using two 67½-volt dry cells connected in series, was decided upon to increase compactness and mobility. The entire ap-

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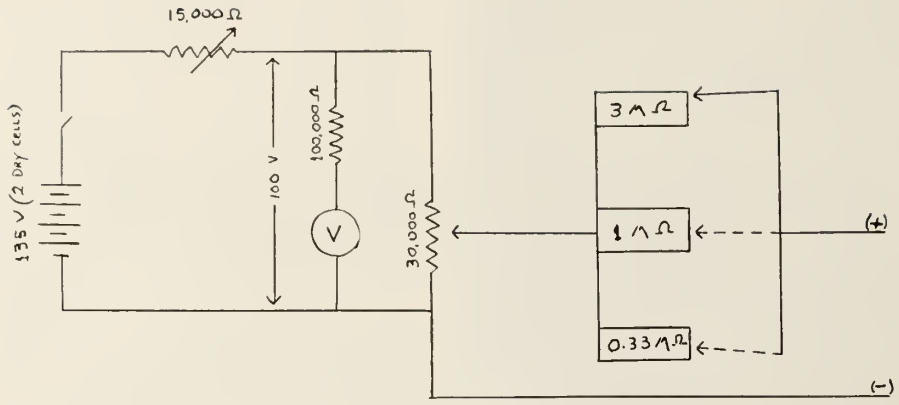


FIG. 1. Schematic circuit for "modified elgustometer." Anode, shaped from stainless steel pin, is used as different electrode and applied to tongue as described. Cathode is used as indifferent electrode and attached to one wrist with routine EKG limb lead.

paratus, save a detachable electrode, is housed in an aluminum box 5½ x 4 x 2 inches. The parts used cost, in toto, about $25.00.

A series of persons considered "normal," and with no complaints of loss or perversion of taste, was tested. These consisted of 39 patients who fulfilled the following criteria:

1. No complaints of disease of the tongue.
2. No disease of the tongue found on physical examination.
3. No past history of paresis of facial muscles.
4. No past history of any variety of ear inflammation.
5. No past history of any trauma to the ear, periauricular area, or face.
6. No evidence of disease of the cranial nerves found on neurologic examination.
7. Normal response to tuning fork testing (Rinne & Weber) at 512 cycles per second.
8. Normal external otitic canal and tympanic membrane by examination.

Reliability of the method seemed good. In all cases, testing was confined to the anterior two-thirds of the tongue. Routine testing was then started on every patient seen by the author who either complained of loss of taste when questioned, or who were felt to be potentially ageusiac in light of history or clinical findings. In the initial series, 39 such patients were seen either at the Albany Medical Center Hospital, or at the Albany Veterans Administration Hospital, Albany, N.Y., from June 1959 to June 1960. Twenty controls were also studied.

Excepting the rare individual who denied any sensation bilaterally at the upper limit of output of the machine, the technic has been found to be readily applicable, easy for the examiner, and acceptable to the patient. In pathologic states, asymmetry of the thresholds on the two sides of the tongue was fairly striking. Consequently, Krarup's "EGUs" have been discarded in favor of recording directly in microamperes, thereby simplifying interpretation.

The machine fell into relative disuse or infrequent use until the past three months. Since that time, it has been made available as part of routine testing offered by the neurology laboratory at Akron General Medical Center. The majority of patients upon whom it has been used at this institution were individuals with facial paresis in whom it was felt necessary to localize the lesion. In other words, loss of taste on the same side as the facial paresis would tend to confirm a typical Bell's palsy with the lesion involving the chorda tympani just before the stylomastoid foramen.

If taste were intact, one might then wonder about such entities as parotid tumors, etc.

In view of the ease of testing, portability of the machine, apparent reliability of the method, and simplicity and cheapness of construction, this apparatus as modified would seem wholly desirable for the routine bedside testing of suspected cases of ageusia.

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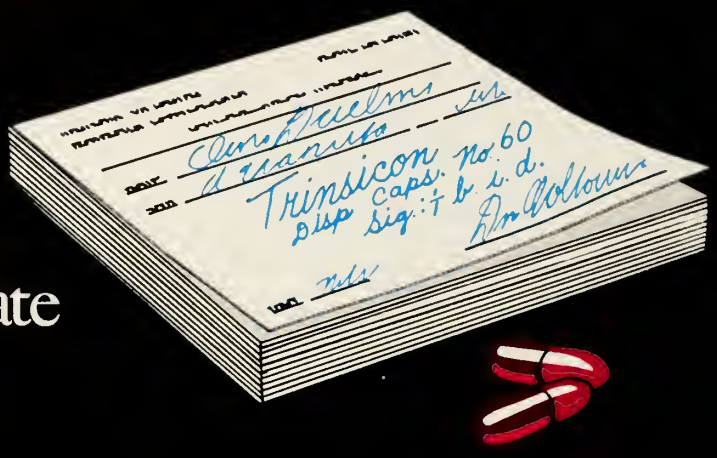
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Indications: Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

Vitamin B_{12} with Intrinsic Factor—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B_{12} in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B_{12} leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B_{12}. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B_{12} deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B_{12} contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B_{12}) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

Folic Acid—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B_{12} deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B_{12} interrelationship: (1) B_{12} influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B_{12} progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B_{12}.

Iron—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

Ascorbic Acid—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

Contraindications and Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B_{12}-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B_{12} may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

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Bilateral Avascular Renal Metastases

A Case Report

Suk Soon Lee, M.D., and Emil Gutman, M.D.

METASTATIC RENAL TUMORS from bronchogenic carcinomas are not uncommon, but they rarely cause symptoms, and therefore, they usually remain undetected until necropsy.[1] Radiographic examination enabled us recently to diagnose such a tumor in one of our patients and to spare him the additional trauma of a useless nephrectomy. The findings, which were confirmed by autopsy, are presented below.

Case Report

A 58-year-old Negro male was admitted to the Veterans Administration Hospital at Dayton, Ohio, on July 16, 1970; he had, for one week, felt pain in the left flank, radiating to the left thigh and the genitalia and accompanied by hematuria and passage of blood clots in the urine.

Past history included an episode of pulmonary tuberculosis in 1962 and left upper lobectomy for cavitating bronchogenic squamous cell carcinoma on April 14, 1970 (Fig. 1). This neoplasm had invaded the pulmonary vein with tumor emboli in the vascular lumen strongly suggesting widespread hematogenous metastasis.

Physical examination on admission revealed an emaciated man who appeared to be very apprehensive and in acute distress from pain. No masses or lymphadenopathy were noted but there was marked tenderness over the left flank, radiating to the thigh and left scrotum.

Urinalysis showed gross blood, albuminuria (4+), and sediment packed with red blood cells. Blood urea nitrogen and creatinine levels were within normal limits, urine culture was negative. Intravenous pyelogram revealed a radiolucent area in the upper pole of the left kidney and inferior displacement of the caliceal system (Fig. 2), however, the collecting system of the right kidney was not well defined. There was no evidence of nephrolithiasis. Retrograde pyelogram of the left kidney afforded a better view and confirmed the findings. The nephrotomogram differed from that of an ordinary cystic lesion (Fig. 3). Selective left renal arteriogram revealed an avascular area in the upper pole of the left kidney with stretching, irregularities, and encasement of the intrarenal arteries without tumor stain (Fig. 4). This led us to suspect metastatic tumor from a primary

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Submitted April 7, 1972.

bronchogenic squamous cell carcinoma. The right kidney was not examined.

On August 6, 1970, the patient was seen again for evaluation of both kidneys and for possible left nephrectomy. His urine was grossly normal, but under the microscope, we found hematuria and 2+ bacteriuria. A new intravenous pyelogram presented the same appearance of the upper pole of the left kidney as before and the same poor definition of the right kidney.

Aortography (Fig. 5) revealed an avascular area in the upper pole of the left kidney and in the lower pole of the right kidney as well as stretching and irregularities of intrarenal arteries. Some encasement was also noted in the lower pole of the right kidney. We now suspected metastatic carcinoma involving both kidneys, due to hematogenous dissemination of squamous cell carcinoma in the upper lobe of the left lung, and we decided against nephrectomy. The patient followed a gradual downhill course and died on September 21, 1970.

Autopsy confirmed our suspicions of metastatic squamous cell carcinoma in both kidneys. Microscopically, these tumors were similar to the primary bronchogenic cancer.

Discussion

Metastatic renal carcinoma is more than twice as frequent as primary malignant neoplasms and is most often secondary to bronchogenic carcinoma. Although these tumors occasionally present as a large single mass, they are usually multiple and bilateral.[2] In 75 to 94 percent of the cases, the metastases proceed via the lymphatic system, and in 75 percent, they are hematogenous.[3] Blood-borne metastases may give rise to emboli, and exploration often results in their more rapid spread.[4] Blood vessel invasion after surgery reduces the five-year survival rate from 75 percent to a low of 6 percent.[5]

Abnormal findings are usually present in the urine. Renal insufficiency or failure is quite rare, even in the presence of fairly marked renal distraction; therefore, attention is often confined to the primary tumor.[1] Urinary tract calculi frequently produce acute flank pain and passage of blood clots from the kidney into the ureter may cause this pain to radiate toward thigh and scrotum. In our case, urolithiasis was suspected at first but pyelography failed to confirm this, and no further symptoms developed to suggest passage of a calculus.

Newsam reported cases with similar histories, symptoms, and clinical findings, where he had advised nephrectomy for palliation.[6]

What is the explanation for the characteristic angiographic signs of this type of metastatic renal carcinoma? We believe that the avascular or hypovascular pattern may be related to (a) the morphology of a poorly vascularized tumor; (b) thrombosis associated with the neoplasm or to



Fig. 1. Thick-walled cavitating lesion in left upper lung field identified as bronchogenic squamous cell carcinoma on surgery.



Fig. 2. Intravenous pyelogram revealing inferior displacement of the collecting system in upper pole of left kidney. Note that collecting system of right kidney is not well delineated.



Fig. 3. Nephrotomogram revealing densities in upper pole of left kidney and lower pole of right kidney. The collecting system of lower pole is distorted, that of upper pole is displaced upward in the right kidney.



Fig. 4. Selective left renal arteriogram revealing encasement, stretching, irregularities, and displacement of intrarenal arteries and avascular area in upper pole.

direct tumor embolism of the blood vessels; (c) external compression of the blood vessels, particularly the veins, by the enlarging tumor; and (d) reactive changes of the vascular wall, especially a significant reactive intimal fibroblastic proliferation of the blood vessels surrounded by the metastatic tumor. The angiographic findings of encasement, stretching, and irregular calibers of the blood vessels may be due to the external compression and related to the previously mentioned vascular wall changes.

Avascular and hypovascular renal metastases can be differentiated from benign cystic lesions and infarcts, in that these latter show neither the tumor vessel pattern nor encasement of the intrarenal vessels, although "amputation" of the artery in metastatic carcinoma may simulate an infarct.[7] Since metastatic spread from a bronchogenic carcinoma is embolic, this appearance can be expected. Infarction has the more classical "bite" appearance of a radiolucent area without the stretching and displacement of vessels. Nephrotomography aids in this differentiation.[7]

Transitional or squamous cell carcinoma of the renal pelvis, which also is usually avascular or hypovascular, may show similar angiographic features. However, it is not likely to displace the collecting system although it may cause hydronephrosis or an intraluminal filling defect. In our case, the collecting system in the upper pole of the left kidney was obviously displaced downward (more evident on retrograde pyelogram) and thus far less likely the sign of a primary renal pelvis lesion.

Some clinicians advocate only selective renal arteriography for a solitary mass in the kidney,



Fig. 5. Aortogram of avascular areas in upper pole of left kidney and lower pole of right kidney with irregularities similar to those in Fig. 4. No tumor vessels are seen.

but we believe that an aortogram should follow, particularly when metastatic tumor is suspected. We actually lost two weeks in trying to evaluate the opposite kidney in our patient, because aortography was not done immediately after the selective (left) renal arteriography.

If a patient has severe flank pain due to metastatic tumor in the kidney, we consider radiation therapy better than nephrectomy for palliation.[8]

Summary

Bronchogenic squamous cell carcinoma was responsible for avascular metastatic tumor of both kidneys. When renal metastasis is suspected, arteriography of both kidneys appears advisable. Once the suspicion is confirmed, therapeutic radiation is considered preferable to nephrectomy for palliation.

Acknowledgement: The valuable assistance of Dr. Y. S. Park and Mrs. Millie Sherron is acknowledged.

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Discussion of E.N.T. Case of the Month

(continued from p. 1018)

This is the characteristic clinical appearance of a mucocoele of the frontal sinus.

This condition occurs when the narrow passage between the frontal sinus and the nose becomes occluded, either due to infection, thickened mucosa, polyps, tumor, or trauma. The closure of this passage allows mucus to accumulate within the sinus, since the glandular elements of the lining mucous membrane will continue to secrete. This results in expansion of the sinus cavity with gradual destruction of the surrounding bone. Eventually, the bone comprising the floor of the sinus thins out, allowing the mucocoele to bulge into the upper medial quadrant of the orbit.

X-ray films of the paranasal sinuses will reveal bone destruction of the supraorbital area. Note in this patient the bone of the left supraorbital area is intact, while on the right (the side of the lesion) it is absent (Fig. 2).

The treatment for this condition is surgical. Two methods of repair are currently used. One method reopens the nasal-frontal duct, leaving the lining of the sinus intact. An alternate but satisfactory method is to expose the sinus cavity and remove the lining mucosa. The cavity then may be obliterated with a free-fat graft from the abdomen. Both methods, as a rule, give good results.

All mucocoeles should be corrected because, if allowed to enlarge, they will eventually cause displacement of the eye with possible stretching of the optic nerve resulting in optic atrophy.



Fig. 2. Bone is absent in right supraorbital area.

Professional Activities



Nation's Women Physicians To Meet in Columbus

THE American Medical Women's Association, Inc., is scheduled to hold its 57th annual meeting in Columbus, November 11-14. Meetings will be held at the Christopher Inn, 300 E. Broad Street in downtown Columbus.

Frances Keller Harding, M.D., Columbus practicing physician, is president of the AMWA this year and will preside at the meeting.

One of the highlights of the meeting will be an address by Carl A. Hoffman, M.D., American Medical Association President, at its House of Delegates' Luncheon, Tuesday, November 14.

The Scientific Session, Monday, November 13, will feature original papers by four prominent Ohio physicians dealing with congenital malformations and the rehabilitation processes. Dr. Margaret J. Schneider, of Cincinnati, will be the moderator of the Scientific Session.

Dr. Blanca Kent, of Columbus, will discuss the "Rehabilitation of Congenitally Malformed Babies: Operations and Late Results." Mary M. Martin, M.D., of Cincinnati, whose paper is titled "Refinishing the Unfinished," will discuss the plastic surgery aspects involved in the rehabilitation of these children. Dr. Ernest W. Johnson, of Columbus, will address himself to the topic of "Rehabilitation as an Art Form," and Claire V. Wolfe, M.D., whose paper is titled "M.D.? Mrs.? . . . PM&R," will discuss the field of Physical Medicine and Rehabilitation and the opportunities it offers to the woman physician.

At the luncheon following the scientific session, Neena B. Schwartz, Ph.D., of the Department of Psychiatry and Biological Laboratories of the University of Illinois, Chicago, will address the group on the topic "Why Women Form Their Own Professional Organizations."

The climax of the meeting will be reached Tuesday, November 14, during the Inaugural Banquet. Awards will be presented in the following categories:

1. The Camille Mermod Award for service to AMWA. Recipient—Mr. Charles Golub, New York, N.Y., auditor for the AMWA for over 20 years.

2. The Elizabeth Blackwell Medal for a woman physician who has advanced the cause of women in medicine, and who has given unselfish and faithful service to the AMWA. Recipient of this award will be Alma Dea Morani, M.D., of Philadelphia, Pa., who is the present president of the Medical Women's International Association.

Mary A. Thomas, M.D., specialist in internal medicine in the Euclid-Cleveland area, is director of junior membership and will be an active participant during the meeting.

The meeting will be concluded with the installation of the new officers for 1973. They are: Ruth Fleming, M.D. of San Francisco, California, President; Margaret P. Sullivan, M.D. of Houston, Texas, President Elect; Catherine W. Anthony, M.D. of Denver, Colorado, First Vice-President; Patricia Tudbury, M.D. of Pomona, California, Second Vice-President; Roslyn F. Pariser, M.D. of Columbus, Secretary; and Dorothy Ruth Darling, M.D. of Gary, Indiana, Treasurer.

Dr. Harding graduated from Loma Linda University and interned at Hollywood Presbyte-

rian Hospital. She is associated with the staff of Grant Hospital and the Ohio State University College of Medicine.

Dr. Harding is a member of the American Medical Association, Ohio State Medical Association, British Medical Association, American Public Health Association and the Columbus Academy of Medicine. She is a life member of Planned Parenthood; Metropolitan Health Council (two terms as president) Columbus; Zonta International (President of Columbus Branch); and honorary member of Mortar Board of Ohio State University; a member of the Board of Florence Crittenden Association of America (Columbus Branch) for six years; a member of the Instructive District Nurses Board of Columbus and Ohio State Health Education Committee, member 16 years and president in 1960.

Dr. Harding has distinguished herself as a leader in all the areas she served. She was chairman of the AMWA Lectureship Committee and reactivated the Alice Stone Woolley Memorial Lecture by personally arranging for speakers in 1967, 1968 and 1969. She served two years as Councilor for Research, Education and Training, Second Vice-President in 1970 and President-Elect in 1971. Dr. Harding is a past president of AMWA Branch #12, Columbus.

As National President of AMWA, Dr. Harding led a delegation of 110 members to the XIII Congress of the Medical Women's International Congress in Paris, France. Her interests have been multifaceted. She has challenged membership to cooperate with others to achieve for each American child "a life of quality." Dr. Harding pledged AMWA to support a program to increase VD awareness which was produced by WNET/13 in October. The program was broadcasted coast to coast and AMWA members were instrumental in securing time for a half-hour live telecast allowing the public to ask specific questions concerning VD.

"More women in medicine" has been her dream, and to this end she has been championing for more women on the admission boards of medical schools. Her travels throughout the year have taken her cross-country many times, representing AMWA at local, state and federal meetings.

Dr. Harding's choice of vocation was in the family tradition. Both her parents were physicians. Her husband, Warren G. Harding, 2nd, M.D., is a Columbus physician. They have three children, one daughter a pediatrician, another a dentist, and their son is a resident in psychiatry and also a lawyer.

Dr. Harding's interests, in addition to "Women in Medicine" with their problems are English History, Georgian Silver and, most of all, her eight grandchildren.

"Disorders of the Eye in Children" will be the topic of a program to be given at the University of Kentucky Medical Center, Lexington, December 15-16. Jonathan Wirtschafter, M.D., is program chairman. Further information may be obtained from Frank R. Lemon, M.D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506. Fee is $90.



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Ohio's Four Medical Colleges Received More Than $50,000 from AMA-ERF Last Year

OHIO'S ANNUAL CAMPAIGN on behalf of the American Medical Association Education and Research Foundation is now under way to make it possible for Medical Education Loan Guarantee programs. Dr. Philip Hardymon, Columbus, is chairman of the Ohio AMA-ERF Committee, which includes councilors of the 11 Councilor Districts of the Ohio State Medical Association.



Dr. Hardymon

Before launching Ohio's 1972 Annual AMA-ERF campaign drive for funds for Medical Education Loan Guarantee Programs, it might be well to quote a few facts which will be of interest to you.

"The total grants distributed to medical schools through the end of the 1971 contributions is $22,779,409."

"For the period March, 1962 through December, 1971 a total of 46,046 loans have been made. The total dollar amount is $51,703,775."

"The four medical schools in Ohio received $50,090.88 from AMA-ERF in 1971 as follows:

"Case Western Reserve University School of Medicine—$10,688.83

"Ohio State University College of Medicine —$13,693.57

"The University of Cincinnati College of Medicine—$19,121.94

"The Medical College of Ohio at Toledo—$6,586.54."

All this has been done by the private sector of the economy without government subsidy. This is an enviable record which can be maintained with the help of Ohio physicians.

But first, here are answers to some questions which you may have concerning the Student Loan Guarantee Fund.

Did you know: . . . That through the Student Loan Guarantee fund, the struggling medical student may receive direct financial aid?

Did you know: . . . That it now costs about $5,000 per year to attend medical school, and more than one-third of the students come from families with gross incomes of less than $10,000?

Did you know: . . . That your contribution to the Student Loan Guarantee Fund will be held as a guarantee for repayment of loans? For each $1.00 you give, another $12.50 will be put to work in loans made by a commercial bank, and as these loans are repaid the money is reactivated to help other students.

Did you know: . . . That the accepted applicant becomes eligible for medical education loans of up to $1,500 a year? Additional applications may be approved each year so that a maximum of $10,000 can be borrowed over a seven year period.

Did you know: . . . That the borrower pays only the established interest rate during his training, and has ten years after completion of training to repay the principal?

The facts stated above are very impressive and the AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine by utilizing the principal of a security fund functioning as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest to medical students.

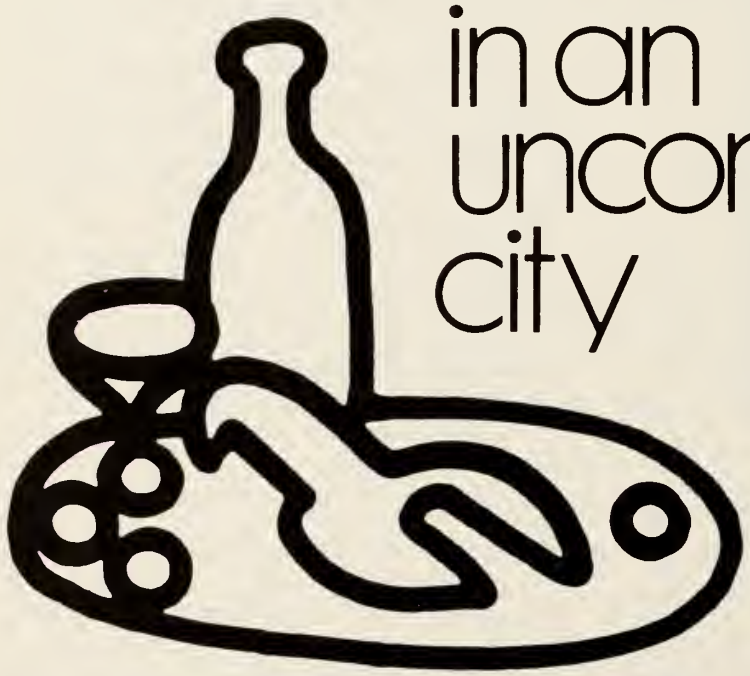
Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

YOU, Doctor, can be an important part of this program by contributing now. Where else can you buy so much for so little? Just think, a contribution of $125 would guarantee a loan for a medical student for one year. Think about it!!

The American Medical Association Is Coming to Ohio . . .

for the 26th Clinical Convention, Cincinnati, November 26-29

an exciting convention in an unconventional city



The Scientific Program — The door to a rich learning experience

Are you as up-to-date in your specialty as you'd like to be? Here's your chance to close the gap and gain continuing education credit besides. Begin with a 3-day total immersion course. Follow up with stimulating conferences, roundtable discussions, the latest medical films, and 250 scientific and industrial exhibits.

Surprising Cincinnati

It's golfing on a challenging course. Yes, *even* in November. It's joy in your youngster's eyes as you thrill to Emmett Kelly's Circus. It's the future melting into the past — skyscrapers amidst quaint homes, old world shops and art galleries. The restaurants? A word of caution: diet *before* you come. Cincinnati — a totally different kind of city. One the entire family can enjoy. Bring yours.

Educational Extras in and around Cincinnati

Dr. Albert Sabin researched the polio vaccine at Children's Hospital. The Medical Laser Laboratory pioneered in using lasers for surgery and dermatology. If you'd like to visit these — the Shriners Burns Institute — or any of the hospitals, labs and research facilities around Cincinnati, the AMA Information/ Entertainment Center will be happy to help you arrange it.

Montgomery County Medical Society Glee Club

To Perform at

AMA Clinical Convention in Cincinnati

November 26

OF SPECIAL INTEREST to Ohioans (and to other convention goers) will be the concert by the Montgomery County Medical Society Glee Club on Sunday, November 26 in the Cincinnati Exposition Center.

The MCMS Glee Club was organized in 1957 by Dr. W. J. Lewis. The group gave its premiere concert before some 400 doctors and their wives in January 1958, at the MCMS Inaugural Ball. Since then the Glee Club has performed for 12 MCMS Inauguration meetings. In 1959 and 1960, they were invited to sing at the Inaugural meetings of the Ohio State Medical Association and in 1961, at the Waldorf-Astoria Hotel in New York, they sang before the American Medical Association Inaugural Meeting. The group has many other concerts before local and national gatherings to its credit.

At the time of its organization the MCMS Glee Club, consisting entirely of practicing M.D.'s was the only one of its kind in the world.

The Ohio State Medical Journal is proud to feature the Glee Club on this month's cover, and points out that proceeds of the concert will go to the AMA Educational and Research Foundation fund. In the cover picture, Dr. Lewis is on the extreme left.

Featured in the insert on the front cover is Bill Hayes, well-known singer and actor of state and screen who will be the principal vocalist for the concert and will present dramatizations peculiar to his style.

His achievements are too numerous to relate here. Suffice it to say that he has starred on the Ed Sullivan Show, the Tonight Show, in the Hallmark Hall of Fame, Bell Telephone Hour, The Interns. He has starred in some sixty theatrical roles, among them Dark of the Moon, George M, Shakespeare's Romeo and Juliet, and so forth.

Make a date now to see this outstanding performance.

— *Turn Page for More on AMA Convention* —

AMA Clinical Convention

Cincinnati, November 26-29

THE Ohio State Medical Association and the Academy of Medicine of Cincinnati will host the American Medical Association for its Clinical Convention to be held in Cincinnati, November 26-29. As members in the host state, Ohio physicians may wish to make a special effort to turn out and welcome their colleagues from all parts of the country.

The AMA House of Delegates will meet on Sunday afternoon, November 26, and again on Wednesday afternoon, November 29.

An excellent scientific program is scheduled beginning on Monday. Scientific features will be in the form of morning postgraduate courses, luncheon roundtable discussions, and the scientific sessions.

Postgraduate courses on three mornings from 7:30 to 8:50 a.m. will include the subjects of blood gases, fluid and electrolyte balance, practical endocrinology, and principles of EKG interpretation.

Luncheon roundtables will include a variety of subjects of practical application in everyday practice. Mailings from the AMA will include details on subjects to be covered.

Scientific sessions begin on Monday at 10:00 a.m. with three concurrent sessions. Monday morning's subjects are cardiac arrhythmias, joint disease, and noninstitutional psychiatry.

On Monday afternoon the subjects will be cardiology, dermatology, and obstetrical problems.

Tuesday morning scientific sessions will begin at 9:00 a.m. and include pediatrics, disorders of the head and neck, and modern trends in gastroenterology.

Tuesday afternoon programs will include pediatric surgery, neurology and neurosurgery, and gastroenterologic problems.

Wednesday morning subjects are infectious disease, urologic disorders, and practical anesthesia.

Wednesday afternoon's scientific sessions will cover diabetes, old problems-new ideas, and the acutely injured patient.

The Scientific Exhibit is always a leading attraction at AMA Clinical Conventions, and this year's is expected to draw special attention. The special exhibit on fractures and another on resuscitation are expected to be centers of interest.

Extra attractions during the meeting will include tours of the Medical Laser Laboratory and the Shrine Burns Institute.

The Second National Open Hearing by the AMA's Council on Long Range Planning and Development is scheduled for Saturday, November 25, on the eve of the meeting.

The 14th National Conference on the Medical Aspects of Sports will be held on Sunday, November 26.

Also on Saturday, November 25 the Council on Medical Service is sponsoring a Conference on Home Health Care.

Another Saturday meeting is the second Business Meeting for all interested Interns and Residents.

The Woman's Auxiliary to the Cincinnati Academy is sponsoring a number of events in which doctors' wives will be especially interested. Also numerous events of interest to children and young people are scheduled, an added incentive for physicians to bring their families.

Special mailings as well as AMA publications will give fuller details on features of the meeting.

Doctor
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***AVAILABLE ON REQUEST:** Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

Why Have Scientific Exhibits?

THIS QUESTION has probably been asked by many of you. You no doubt wonder: Is a scientific exhibit worth all the time, energy and money spent on its preparation? We have attempted to answer this question along with others which you may have in the Guidelines on to Exhibit or not to Exhibit . . . That is the question.

The scientific exhibit is a very much neglected method of continuing education. We tend to forget that the scientific exhibit offers one of the best methods of disseminating information because it stimulates perception both visual and auditory. The prime purpose of a Scientific Exhibit is to convey knowledge in clinical and research medicine. It represents an effort in continuing medical education which is practical as well as highly efficient. It has been said that "the teaching potential of exhibits is probably higher than other known media within a given time and space relationship and the exhibitor is the most important single element in the presentation."

This article with Guidelines on how to prepare and make plans for an exhibit has been prepared with YOU (the exhibitor) in mind. We challenge you to enter your scientific exhibit at the 1973 OSMA Annual Meeting, be a leader by sharing your medical knowledge with your fellow physicians. We are certain you will find it an avenue of continuing medical education that can answer many questions and will be a most gratifying experience not only to YOU (the exhibitor) but your fellow physicians.

Join the "Educare: 1973" team by entering an exhibit. The exhibit application form is on an accompanying page. Please clip and mail to the OSMA Office. Further details on Rules and Regulations are available from the headquarters office.

GUIDELINES FOR SCIENTIFIC EXHIBIT PREPARATION

I. Planning the Exhibit

A good exhibit should be planned many weeks, and sometimes months, before the meeting at which it is to be shown. When the main ideas have been decided on, all the material pertaining to the idea should be collected and sorted. It will be impossible to show everything. The results of experimental work must include the necessary controls, showing the failures as well as the successes.

KEEP IT SIMPLE: Rule Number One — Don't clutter up an exhibit by covering too many ideas, too wide a range, too many facts and figures or with too many colors. Many exhibits suffer from an overdose of elements. One might start by following these five steps:

a. Choose a subject or theme.

b. Gather factual information.

c. Boil down the information to the minimum amount of words.

d. Highlight one idea.

e. Try to obtain models, photographs, artifacts, charts, et cetera, to back up main idea.

Before proceeding with your exhibit ask yourself the following questions:

(1) Is the subject of sufficient interest to attract the general visiting physician?

(2) Is the subject of current interest?

(3) Would you cross the country to see this exhibit?

(4) Does the subject lend itself to a visual presentation?

(5) Can the subject be told rapidly and with great accuracy?

II. Construction of the Exhibit

Depending on the overall design of the exhibit, the construction phase may be complicated and require the use of a cabinet maker or it may be simple and be put together with the use of a hammer, a saw, and a square. Visit your local cash and carry lumber store for all your "gimmick" appliques. Fancy cabinet work does not make a poor exhibit into an award winning exhibit. Important subject matter, however, will always attract interest no matter how poorly presented, but the aim is to present the material in such a pleasing manner that the viewer is aided in retaining the material.

The budget, of course, will be the final judge of the type of construction used in the presentation, so no rules or guidelines can be established in this article. It is well to get the expert advice of a cabinet maker at this point to make an estimate of the construction costs before actually starting. His suggestions may actually lower the overall cost.

III. Letter Size and Style

The size and style of letters used for text material, as well as, labels and heading should

be carefully considered since the readability of the message is based to a large extent on them. In keeping with the overall discussion on planning, letter size can do a great deal to assist the visitor in his understanding of the subject.

The largest letters should be the title and subtitle since the observer makes his first decision to stop in the booth, based upon his interest in the subject. These letters should be at least 1 inch in height and of a generally simple form without fancy curlicues. The color chosen for the background will have everything to do with determining the color for the letters since readability increases with contrast. Black letters on white or white letters on black have the greatest contrast so choose a letter color that approaches this contrast.

The next most important area to the viewer is a brief, but comprehensive statement of purpose or introduction. From this the viewer is able to determine whether the subject is of sufficient interest to warrant taking the time to study the details. Since this area will probably be read from at least ten feet away, the letter size should be at least ½ inch in height, preferably in upper and lower case for readability purposes.

The main body of material, including labels, will be viewed from 5 feet or less since the viewer has shown an interest in the exhibit. These letters can, therefore, be on the order of ¼ inch in height depending on the lighting and length of copy. Be certain that the smallest size lettering used is placed at or near eye level for convenience in reading.

With the advent of lettering devices and dry transfer letters, there appears to be little reason to do hand lettering unless it is done by a professional. The dry transfer letters come on sheets in many styles, but again, stick to fairly simplified styles for readability. Most art supply dealers carry a large supply of this type of material. The use of typewritten labels should be avoided since they are too small for easy reading.

IV. Charts and Graphs

The chart or graph is a visual tool to take the place of descriptive words or statistical material. As such it should be simple, bold and able to be comprehended. If the chart must be explained, its purpose has been defeated. A common failing is to place too many items on one graph, such as complicated groups of bars or criss-crossing lines. Statistical material is logically presented in graph form since it leaves a visual impression without being a burden as far as details are concerned. Care must be taken, however, in the preparation of such charts to present the material in a truthful and non-biased manner.

V. Photographs, Drawings and Illustrations

In using photographs, drawings or illustrations, care must be exercised to include only those which make a definite contribution to the overall presentation. They should never be used just because they look nice. Simplified drawings very often have advantages over photographs in that all extraneous matter may be omitted, thus emphasizing the main point of interest. Color in drawings or illustrations adds to the overall eye appeal in addition to making them understandable. In using photographs, non-glossy prints are a decided advantage due to the fact that they do not reflect light.

VI. Sounds, Motion and Patients

There are many "gimmicks" that may be used to aid the presentation, but they should all be used with restraint and not put in as merely "attention getters." An exhibit is not a side show, but a teaching mechanism and as such it must be looked at for its educational value. The audience for this teaching mechanism is already sold on its advantages, so does not need to be convinced of its worth.

Occasionally, a short motion picture is needed to show an actual technique that is difficult or impossible to explain with words or still illustrations. The same holds true for sound machines. A tape recording, however, to explain a procedure or the results of a study is better done in person by the exhibitor. If sound is needed to enhance the presentation, it should only be played through earphones and not a loudspeaker. Invariably, sound from a loudspeaker will be disturbing to adjacent booths and makes for utter confusion.

VII. Practice Installation

When the exhibit has been completed, it should be set up just as it would be in the exhibit hall and any weaknesses noted and corrected before actual shipping.

At the time of the meeting it is expensive as well as frustrating to attempt to correct faults since labor is not familiar with your exhibit. The practice installation will also alert the exhibitor to the need for accessory items that should be taken to the meeting. The accessory items probably would include small hand tools, masking tape, touch-up paint and brushes, soap to scrub off finger prints and a set of instructions for ease in installation.

VIII. The Exhibitor

An unattended exhibit loses about fifty per cent of its value. The attendant should be the



1973 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1973 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be Monday through Wednesday, May 7, 8 and 9.

Mail applications to the attention of Jerry J. Campbell, Exhibit Manager, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1973 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 7, 8 and 9

1. Title of Exhibit:_____
2. Name(s) of Exhibitor(s):_____

   Institution (If desired):_____

   City_____
3. Do you have a built-in exhibit?_____
4. Booth Requirements: Back wall _____ All side walls are 6′ deep
   (indicate footage)
5. Description of Exhibit: (Attach 200 word description to this blank)

Deadline For Filing Applications, February 1, 1973

research worker who is thoroughly conversant with all details.

The exhibitor is the single most important element of an exhibit since the exhibit proper is merely a backdrop to impart general information and introduce the observer to the subject. An exhibit can only give the highlights of study or research project since wording is normally kept to a minimum. The exhibitor who gives himself freely to the task of imparting knowledge will be amply repaid. For an effective presentation, he should be guided by the following principles:

(a) The exhibitor should be the person responsible for the study or research on which the exhibit is based or an assistant who is knowledgeable with all of the details. To have an uninformed individual in the booth is like the author of a paper asking someone to read his paper before an important meeting.

(b) The exhibitor should be present in the booth for the major portion of each day. Nothing is more unfair to the viewer than having an empty booth. If he has pertinent questions to ask, he will have to make a special effort to return. The exhibitor who has one or more associates who can relieve him from time to time is indeed fortunate.

(c) Don't fall into the category of the overaggressive demonstrator and scare off visitors. The good exhibitor allows the visitor to peruse the information at his leisure, while at the same time making himself available to answer questions.

Acknowledgements: Parts of this article are reproduced with permission from material furnished by the Southern Medical Association, Birmingham, Ala., and the Scientific Exhibit Section of the AMA, Chicago.

Ohio Surgeons Receive Fellowships from ACS

Some 64 Ohioans were among approximately 1,527 initiates inducted as new Fellows of the American College of Surgeons at the organization's recent clinical congress in San Francisco.

Fellowship, a degree entitling the recipient to the designation "FACS," is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

A list of Ohioans honored with Fellowships will be sent by The Journal staff to any Ohio physician who requests it.

MDs in the News

Dr. Arthur G. James, Columbus, is the 1972-1973 president of the American Cancer Society.

Dr. Robert G. Page, dean of the Medical College of Ohio at Toledo, was one of some 53 medical educators who presented papers at the Fourth World Conference on Medical Education in Copenhagen. His topic was "Professional Organizations and Other Agencies as Factors Which Effect Change."

Dr. Herbert S. Bell, Cleveland area neurosurgeon, won first place award for his scientific exhibit shown at the American Medical Association Annual Convention in San Francisco in June. It was entitled "The Principle of Spring Loaded Points for Cervical Traction."

Grant Would Promote More Physicians for Underserviced Areas

A student aid grant of $70,850 will enable the University of Cincinnati College of Medicine to increase by a small percentage its enrollment of women students, students from rural backgrounds, and minority-group students.

The grant, supplied by the Robert Wood Johnson Foundation, Princeton, N.J., provides support over the next four academic years for scholarship and loan awards to students in these categories. These are considered by the foundation as most likely to practice in rural and inner-city communities.

Individual recipients and amounts will be determined by the College of Medicine and not by the foundation.

The grant is part of a $10 million program to aid the nation's 108 schools of medicine and seven schools of osteopathy in increasing the number of future doctors likely to enter practice in medically underserviced areas.

Dr. James A. L. Toland has been appointed acting superintendent of the Cambridge State Hospital to succeed Dr. James K. Gibson who recently retired.

Ohio Listing of Volunteers for Vietnam Program

Ohio has an enviable record of physicians who served tours under the Volunteer Physicians for Vietnam program sponsored by the American Medical Association. Under this program, a physician serves a tour of 60 days in South Vietnam giving medical aid to civilians. The need is great, not only because of a war-torn country, but because most Vietnam physicians are involved in military medicine.

The Agency for International Development has urged the American Medical Association to continue the program, and the AMA is hoping for an additional hundred volunteers for 1973.

Additional information may be obtained from the AMA Headquarters at 535 N. Dearborn Street, Chicago, Illinois 60610.

The following listing of Ohio physicians who have served under the program was compiled by the VPVN program directors and checked against records in the OSMA office. Please indicate to *The Journal* staff any corrections or additions.

Peter Amenthorp, Middletown
Jack P. Baldwin, Cincinnati
William E. Barratt, Painesville
Jack R. Bontley, Columbus
William R. Brinker, Ravenna
Robert C. Cahill, Attica (two tours)
Benjamin B. Caplan, Columbus
Robert Eugene Cooke, Harrison
David M. Creamer, Bellaire (two tours)
Charles J. Cross, Columbus
Walter W. Donahue, Leipsic
James Quinn Dorgan, Jr., Columbus
Louis J. Finkelmeier, Celina
Robert Martin Foster, Youngstown
Frank Gatti, Portsmouth
Joseph H. Gaudreault, Hinckley (three tours)
Aaron I. Grollman, Cincinnati
Charles U. Hauser, Hamilton
Mark T. Hoekenga, Cincinnati
C. W. Hullinger, Springfield
William H. Jeric, Cleveland (two regular and a long tour)
Hobart E. Klaaren, Dayton
Paul A. Milde, Cleveland Heights
Alexander Miller, Cleveland Heights
Paul R. Miller, Columbus
William F. Mitchell, Columbus
Wallace Mulligan, Shaker Heights
Stanley H. Nahigian, Cleveland
Anthony C. Nassif, Seven Hills
Ranier S. Pakusch, Maumee
James B. Patterson, Lorain
Thomas Prescott, Mt. Vernon
Jerry C. Rosenberg, Toledo

(Volunteers—Contd.)

William P. Skivolocki, Columbus
Buel S. Smith, Akron
Robert G. Smith, Circleville (two tours)
Robert E. Sooy, Mt. Vernon
John E. Stephens, Columbus (four tours)
Clinton W. Trott, Mt. Vernon
Ladislao K. Wallerstein, Toledo
Robert L. Wick, Jr., Worthington
Lois R. Zimmerman, Tiffin

The University of Kentucky is sponsoring a "Pediatric Ophthalmology Conference" to be held in Lexington, Ky., December 15-16. The fee is $75 for practitioners and $10 for residents and fellows. For details contact Frank R. Lemon, M.D., Associate Dean for Continuing Medical Education, University of Kentucky, Lexington, Ky. 40506.



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Nose clear all knight

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

Dimetapp® Extentabs

Dimetane® (brompheniramine maleate), 12 mg . phenylephrine HCl, 15 mg . phenylpropanolamine HCl, 15 mg

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.

CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.

WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.

PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.

ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.

HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

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memory of yesterday's pain...
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Phenaphen with Codeine No. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3) or 1 gr. (No. 4) (warning: may be habit forming).

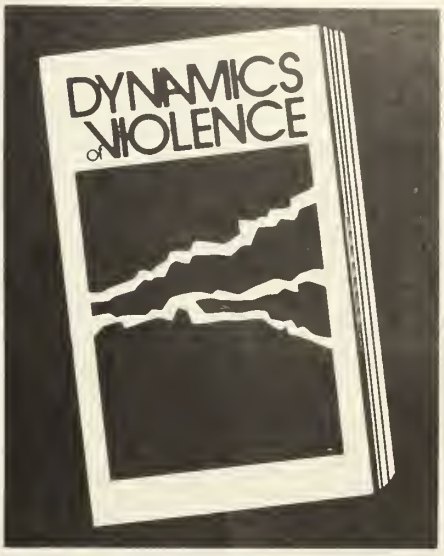
Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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SMJ 11/72

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When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

nfections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

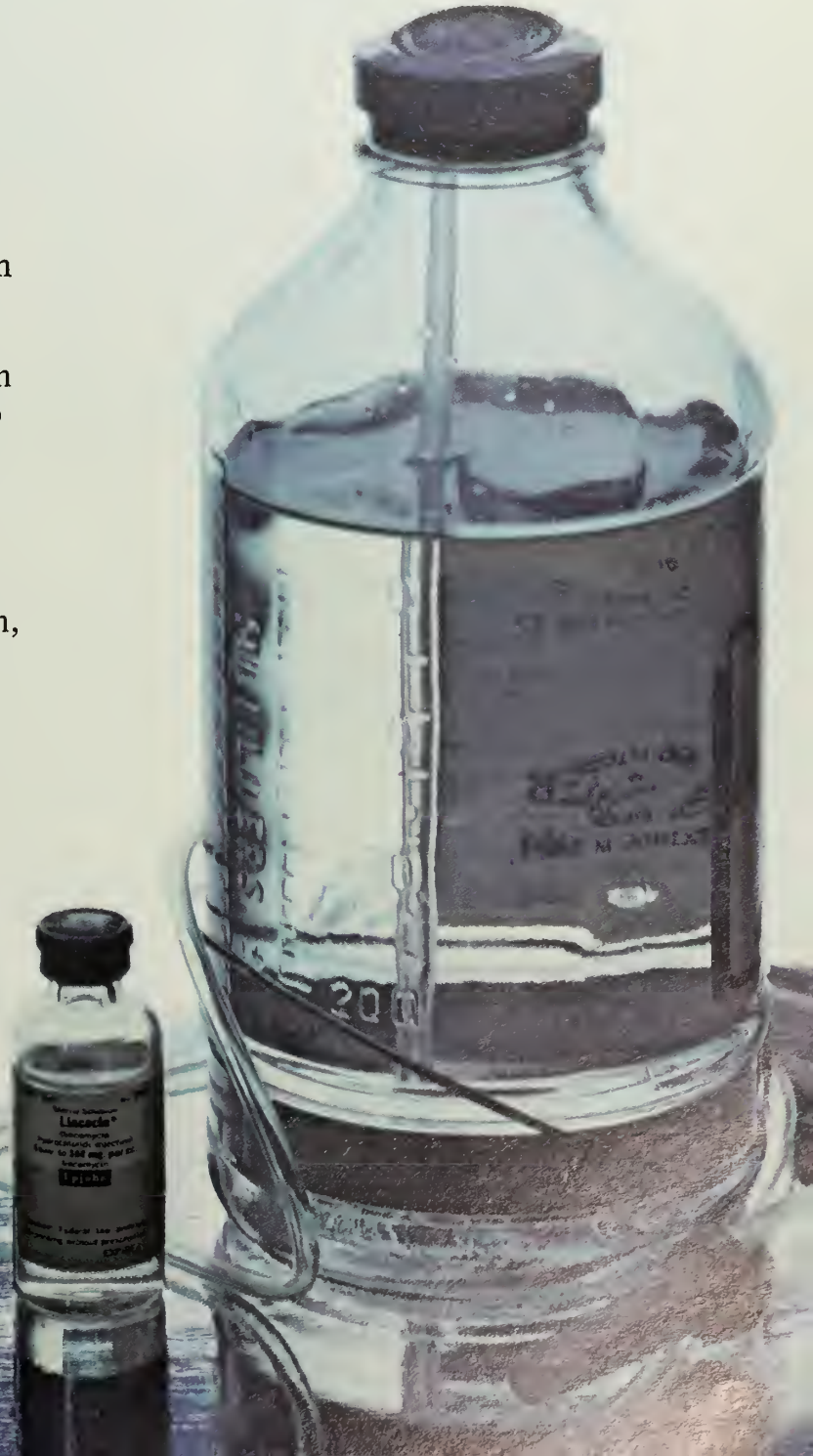
Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatmen *Skin and mucous membranes*—Skin rashe urticaria, vaginitis, and rare instances of e foliative and vesiculobullous dermatitis hav been reported. *Liver*—Although no direct re lationship to liver dysfunction is establishe jaundice and abnormal liver function tes (particularly serum transaminase) have bee observed in a few instances. *Cardiovascul* —Instances of hypotension following paren teral administration have been reporte particularly after too rapid IV administra tion. Rare instances of cardiopulmonary a rest have been reported after too rapid I administration. If 4.0 grams or more admi istered IV, dilute in 500 ml of fluid an administer no faster than 100 ml per hou *Special senses*—Tinnitus and vertigo hav been reported occasionally. *Local reactio* —Excellent local tolerance demonstrated intramuscularly administered Lincoci (lincomycin hydrochloride). Reports of pa following injection have been infrequen Intravenous administration of Lincocin 250 to 500 ml of 5% glucose in distill water or normal saline has produced r local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 m* Capsules—bottles of 24 and 100. *Steri Solution, 300 mg per ml*—2 and 10 ml via and 2 ml syringe. *Syrup, 250 mg per 5* —60 ml and pint bottles.

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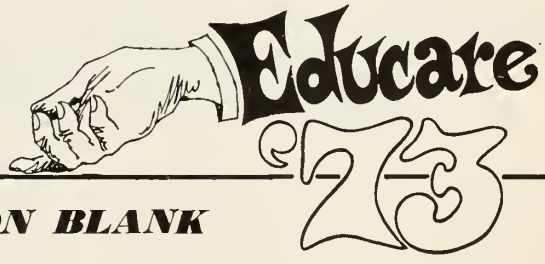
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National AMA Meeting on Sports Medicine

The 14th National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Cincinnati at the Sheraton-Gibson Hotel on November 26. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

As was true of the previous thirteen Conferences, the 14th will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be forums and discussion sections relating to epileptics in contact sports, sports equipment, the young athlete, excessive weight loss among wrestlers, state medical societies, the family physician's role in sports medicine, drugs in sports and the olympics in retrospect.

At the Conference Luncheon, William K. Keller, M.D., assisting physician at the Indianapolis 500, and chairman of AMA's Committee on the Medical Aspects of Automotive Safety, will discuss the topic "The Indianapolis 500." At the evening session consultations and demonstrations on preventive and therapeutic taping, equipment fitting, devices to assess environmental heat stress and physical examinations will be staged.

The Conference is open to athletic nonmedical personnel, allied medical professionals and physicians. Those who would like to receive further information concerning the Conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Cincinnati Gets Grant for Lipid Research Program

HEW's National Heart and Lung Institute has awarded six contracts totalling $2.81 million to establish six new Lipid Research Clinics at medical institutions in various parts of the country as part of expanded nationwide attack on arteriosclerosis.

At the same time, for an additional $2.54 million the Institute renewed contracts for the Lipid Research Clinics it established earlier.

Overall objective of the program is to develop improved methods of preventing coronary artery disease and other complications of arteriosclerosis.

The contracts bring to 13 the total number awarded since July 1971 at a cost totalling $7.92 million.

One of the grants amounting to $470,000 went to the University of Cincinnati for a program in which Charles Glueck, M.D., is principal investigator.



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Soyalac is palatable, readily digested and assimilated. It simulates human milk in appearance, taste, texture. It is complete with vitamins and minerals. It is equally suitable for children and adults allergic to cow's milk.

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Obituaries

Harry Stephen Berlesky, M.D., Barberton; George Washington University School of Medicine, 1933; aged 66; died September 11; member of OSMA, AMA, and American Academy of Family Physicians; native of Barberton and practitioner there for some 40 years in the fields of general practice, gastroenterology and cardiology; veteran of World War II.

Samuel Bartholomew Cowen, M.D., Cleveland; University of Colorado School of Medicine, 1911; aged 86; died September 13; member of OSMA and AMA; diplomate, American Board of Otolaryngology; formerly on the faculty of Case Western Reserve University College of Medicine; practitioner of long standing in Cleveland specializing in the EENT field. His wife and a son Richard are physicians.

John Tipton Gibbons, M.D., Logan; Ohio State University College of Medicine, 1915; aged 84; died August 24; member of OSMA and AMA; moved to Logan early in 1971 after practicing for many years in Celina where he founded the Gibbons Hospital; former coroner of Mercer County; veteran of both World Wars I and II.

Moses T. Knappenberger, M.D., Warren; Ohio State University College of Homeopathic Medicine, 1915; aged 80; died August 27; member of OSMA and AMA; practitioner in general and industrial medicine for many years in Warren; Warren city health commissioner; veteran of World War I.

Andrew Kovacs, M.D., Cleveland; Eclectic Medical College, Cincinnati, 1927; aged 73; died August 31; member of OSMA; general practitioner and general surgeon for some 40 years in Cleveland.

Howard Ellsworth Mathay, M.D., Youngstown; Western Reserve University School of Medicine, 1931; aged 67; died September 26; member of OSMA, AMA, American Academy of Family Physicians, and Industrial Medical Association; practitioner of long standing in Youngstown; retired in 1970 as medical director for the Youngstown District, U. S. Steel Corporation.

Hanns B. Mueller, M.D., Cleveland; University of Goettingen, Germany, 1920; aged 79; died September 4; practitioner in the Cleveland area since 1943.

George F. Munns, M.D., Palm Desert, Calif.; University of Cincinnati College of Medicine, 1923; aged 74; died August 29; left Ohio after completing his medical training and practiced for many years in Winnetka, Illinois.

A. David Price, M.D., Chardon; Indiana University School of Medicine, 1939; aged 61; died August 24; member of OSMA, AMA, and American Academy of Family Physicians; general practitioner for some 32 years in the Chardon area.

Myrta M. Adams Reed, M.D., Cincinnati; Rush Medical College, 1923; aged 75; died September 11; member of OSMA, AMA, and American Academy of Family Physicians; former medical missionary, and practitioner for many years in the Newtown area of Greater Cincinnati.

Huston H. Rinehart, M.D., Venice, Fla.; University of Cincinnati College of Medicine, 1934; aged 68; died August 31; member of OSMA and AMA; general practitioner of some 35 years' standing in the Wyoming area of Cincinnati before his retirement in 1967.

Earl Anton Simendinger, M.D., Tampa, Fla.; University of Cincinnati College of Medicine, 1938; aged 60; died September 20; member of OSMA and AMA; Fellow, American College of Surgeons; diplomate, American Board of Surgery; Akron surgeon in private and industrial practice for many years; moved to Tampa in 1969 and became medical director for the General Telephone Company of Florida.

Kernoyler Webb, Jr., M.D., Cleveland; Howard University College of Medicine, 1953; aged 45; died September 16; member of OSMA and AMA; practitioner for about 12 years in Cleveland; served with U. S. Navy during World War II, and served as a flight surgeon with the Air Force from about 1954 to 1960.

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

HAVE YOU EVER WONDERED what it would be like to see yourself on television—and HEAR yourself? It can be quite a shock! Ask the 25 doctors' wives (auxiliary members, but of course) who participated in that recent Speakers' Bureau "special" sponsored by the Ohio State Medical Association. Held at the Sheraton-Columbus on September 21 and 22, and directed by Robert Lang, executive secretary of the Academy of Medicine of Cleveland and Cuyahoga county, it proved to be an enlightening and stimulating experience. And a bit frustrating and ego-shattering when you watched yourself and heard yourself on the play-backs!

But we were there to learn and listen and absorb. And that we did. Along with Mr. Lang, the "faculty" included Alexander Lagusch, assistant executive secretary of Cleveland's Academy of Medicine, and Charles W. Edgar, OSMA's director of public relations and assistant executive director. And there was cameraman Bill Smith who focused on us individually and then later showed us how we looked and sounded. . . .

I'm going into quite a bit of detail on the state auxiliary's first speakers' training seminar because I feel that much of what the 25 "fledglings" learned and experienced can well be passed on. At one time or another, most doctors and their wives are called upon to address some kind of group, not necessarily in a formal manner, but nonetheless to explain or interpret or emphasize a particular point or points. It certainly can be helpful to be made aware of voice inflection, eye projection, gestures and movement. It certainly can be helpful to realize the importance of WHAT you say and HOW you say it.

"Taking Off"

At 1:15 p.m. at the first afternoon session, the dynamic Mr. Lang discussed "How to Make a Speech" with emphasis on delivery. In discussing "How You Say It," he spoke of the tone of the voice and how a good voice can arouse interest. He also pointed out a speaker cannot permit such emotions as anger to take over. He commented that in women there is a tendency for the voice pitch to rise because of nervousness. Looking your audience "in the eye" is an important asset, we were told (I discovered, much to my chagrin, that I had a tendency to look skyward!) There should be action—gestures and movement (but not paper rattling).

In talking about "What You Say," emphasis was placed on content, the importance of an outline, the extemporaneous style and the choice of simple words. And the importance of dividing an outline into three divisions: 1) Introduction; 2) Discussion on not more than three major points and 3) Conclusion.

Of tremendous help was the packet "Speakers' Program" put out by the American Medical Association which each of us attending the seminar was given. There is one brochure on "TV Do's and Don'ts," another on "Speaker's Check

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List," and a great big thick one on "So You Want to Make a Speech."

Also scheduled was a Speakers and Leadership Seminar for the doctors (sponsored by the AMA and the Ohio State Medical Association) in Columbus on October 23 and 24 at Scot's Inn. Robert Lang will again be participating, along with Mortimer T. Enright, director of Speakers and Leadership Programs of the AMA and T. Stephen May, Ph.D., associate professor, radio-television-film, School of Speech, Northwestern University.

Other Highlights

Back to our first day's session—at 2:00 p.m., each of us was given a prepared one-minute manuscript which was video-taped. And then the playback—and the comments and criticisms of the faculty. This was a most helpful portion of the program. By watching not only ourselves but our colleagues, and listening to the comments and criticisms we received a valuable lesson in what to do and what not to do when reading directly from a manuscript on television, or for that matter, just making an appearance on television! Or before any audience anywhere. . . .

The most difficult session, however, was yet ahead of us. That had to do with the practice period on 3-minute speeches (prepared from an outline done "on the spot" on any subject of our choosing), and then followed by the videotaping. The group was divided into three sections for practice, with Mr. Lang conducting one session, and the other two handled by Mr. Edgar and Mr. Lagusch. We managed to live through it, but you can believe we were more than ready for the 5:30 p.m. respite—dubbed on the agenda as "Nervous Tension Control Session and Dinner."

And if you think that, following the social hour and dinner, we were dismissed for the night, you're wrong! "Special Events," said the agenda, from 7:30 to 9:00 p.m. (more or less). As it turned out, tired though we were, we profited greatly from Mr. Lang's general assessment and subsequent two "interviews" (each a make-believe extemporaneous television interview) that was excellent training.

Friday Morning

It was 8:30 in the morning, but the 25 auxiliary trainees were "bright-eyed and bushy-tailed" and eager to get on with the Speakers' Bureau seminar. A bit apprehensive too, to be sure, because the videotaping the previous afternoon of the three-minute speeches would be played back. Well, they were—and there was a question and answer period as well. Know what? We weren't half bad! In fact, our faculty of three gave us all passing grades, and most helpful comment (and I don't think they were trying to be TOO easy on us!!)

We may not end up as another William Jennings Bryan or a Robert A. Lang or a Charles W. Edgar or an Alexander Lagusch, but I do think the 25 doctors' wives who attended the seminar can do a creditable job for the auxiliary and medical profession. And they can help in training other doctors' wives as speakers.

This is all a vital part of the new national auxiliary format and its emphasis on health education. As auxiliary members, we must not only know **what** we are talking about (and that means being as thoroughly informed as possible, but we must also know **how** to inform others effectively and how best to communicate in our counties. If we are to help the cause of medicine and serve the needs in our individual communities, we must learn to use the magic of the spoken word.

That, in essence, summarized the Speakers' Bureau seminar that Friday morning. Mr. Lang and Mr. Edgar led a lively discussion on "Where Do We Go From Here?" "How to Handle a Speaking Engagement—Live, Radio, TV" and then threw the session open to any and all questions. That there were plenty of questions probably does not even need to be said!

On behalf of all the women who participated in the seminar, our most grateful thanks to the Ohio State Medical Association, Mr. Lang, Mr. Edgar, Mr. Lagusch and Mr. Smith. We sincerely hope that our "teachers" experienced as satisfying a sense of accomplishment as we did. . . .

Woman in the News

Mayor Ralph J. Perk, of Cleveland, has recently appointed Mrs. Christopher A. Colombi as a trustee of the Metropolitan Health Planning Corporation, the comprehensive areawide Health Planning Agency serving well over two million people in Cuyahoga, Geauga, Lake and Medina counties.

Mrs. Colombi (more familiarly "Vi") is a past state president and current chairman of program development. In fact, we are deeply indebted to her for helping to set up the Speakers' Bureau seminar just described in this column.

The Metropolitan Health Planning Corporation, says Mrs. Colombi, has under consideration such subjects as health manpower, kinds and locations of hospital facilities, services for ambulatory care of the medically indigent, pollution, nursing

homes and extended care facilities, costs of medical care and the reduction of mentally ill patients.

Vi Colombi has been selected by the last three mayors in Cleveland—two Democrats and one Republican—to work for the betterment of community health. Which certainly proves that a dedicated auxiliary member can be nonpartisan where service to her fellowmen is concerned. We are happy to salute this outstanding doctor's wife. . . .

Around the State

The **Lucas County** auxiliary has come up again with an intriguing calendar of events for the 1972-73 year. These auxilians are emphasizing the "New Look" for the current period and I give you a bit of preview:

For September: It's "Take A Look" at the exciting line-up of new and old study groups offered Monday through Friday, afternoons or evenings. I hesitate to say that no other auxiliary in the state has a study groups program because I just don't know—but I doubt if any one group could top the Lucas program. By way of detailing it, there are offered this year: Antiques and Art Glass; Art Classes; Beauty through Ballet; Bridge; Ceramic and Sculpture; French Conversation; Gourmet Group; Investment Group; Knitting Class; Psychic Interest; Spanish Conversation; Swimming and Exercise; Tennis Clinic; and if enough interest is shown, there may be such new groups as those in handwriting analysis; ecology; consumer interest; nutrition; sewing; astrology; yoga; weight watchers; photography, and so on.

These study groups operate the full auxiliary year (the "for September" indicated above meant only that the members were being asked to "take a look" and then make a choice!)

In November, there's "A Look At China," when Dr. Kenneth Levin will tell of his experiences and impressions as one of the first American citizens to visit China. Later programs feature "Let's Look at Health Foods, Diets, Vitamins E, K and C, and some Niacin too" with Dr. John Conlande of the University of Michigan, plus a panel of auxiliary members; "It's the Look of a French Restaurant" and "The Look of Recognition"—the first annual health service volunteer awards to be presented to the women of Toledo and Lucas County. There are some other "New Looks" too, but I must save some of these for future columns! Lucas County's first luncheon meeting of the year was held on October 10 at the Academy of Medicine. It was "let's get together time" and "If Not Now" with Joyce Feurring and Evelyn Orbach.

District 11

The **Richland County** auxiliary hosted members of District 11 at an all-day meeting on October 2, starting at the home of Mrs. Donald Dewald, district director. Women from a five-county area were greeted by members of the Mansfield delegation. A coffee hour started off the day's activities. Guest speakers included Mrs. Louis Loria, state president; Mrs. Karl Ulicny, state president-elect; and Mrs. Malachi W. Sloan, II, North Central Regional Legislation Chairman.

Following the morning activities, the nearly 100 women moved on to a luncheon at the Possum Run Golf and Swim Club's Gourmet Room. Hosting the luncheon was Mrs. P. O. Staker. The tables were decorated with red, white and blue floral arrangements made by Mrs. James O. Ludwig. Even Richland County's president, Mrs. Harley Lindquist, was in tune with the decorations—her red, white and blue shift was printed with the words VOTE . . . .

Also in keeping with the red, white and blue theme was the talk of Mrs. S. B. Pfahl, state legislative chairman, who discussed current bills in the state legislature.

Excellent newspaper coverage of the District 11 meeting was given by Mansfield's *News Journal*. It merited feature story prominence, along with some fine pictures (including one of Eileen Loria autographing the cast on the broken leg of Jane Sloan! Sorry, Jane—I didn't know about it—but even a broken leg can't keep you down, can it???)

Scioto County

There's a lot of auxiliary activity, down here in Southern Ohio. Mrs. David E. Livingston, **Scioto** president, called her first Board meeting on August 28, at which several important business matters were discussed.

The first general meeting of the new auxiliary year was held on September 13 with a luncheon at Harold's Restaurant in Portsmouth. A most unusual donkey and a most unusual elephant (they really were terrific!) decorated the speakers' table in honor of Mrs. Malachi W. Sloan, II who presented the legislation picture, the importance of voting and the proposed health insurance legislation with clarity and pithiness and interest. Hostesses for the September meeting were Mrs. Robert Counts, Mrs. William Daehler, Mrs. J. P. McAfee and Mrs. John Temponeras. Mrs. Livingston presided at the business session.

A Night to Remember

Scioto auxiliary has been doing it for several years now—the annual international dinner to which the doctors are invited as honored guests.

And each year the food of another country is featured, and the theme is centered around that country. This year it was a Hawaiian Luau. Of course, Hawaii is a part of these United States, but it certainly has an entity all its own!

The home and beautiful grounds of Dr. and Mrs. Louis Chaboudy in Portsmouth were the scene of this year's event and a more beautiful scene cannot be imagined. The flares, the tents with colored lights strung the full length of the dining area, the Hawaiian music and luscious Hawaiian food gave the illusion of Hawaii itself, even to the flowers, languorous air and soft breezes. Those who assisted Mrs. Chaboudy with the festive occasion included Mrs. Robert Martin, Mrs. Manuel Pezeshki, Mrs. Jerome Rini, Mrs. Harlan Williams, Mrs. William Daehler, Mrs. Ralph Herms, and Mrs. John Walker.

Doctor's Day

The **Tuscarawas** auxiliary honored its 41 active doctors on September 24 with a Doctor's Day observance. As the men entered the county's two hospitals, they were given red roses for their lapels. Mrs. H. F. VanEpps and Mrs. Joseph Hamilton did the honors at Union Hospital in Dover; Mrs. R. A. Wilson made the presentations at Twin City Hospital in Dennison. The special day culminated in a dinner at Bonvechio's at Wainwright, with Dr. Jack Schreiber, of Youngstown, as guest speaker.

The committee for the dinner included: Mrs. Hamilton, Mrs. James Houglan, Mrs. G. S. Tripathy and Mrs. F. F. Gonzales. Tuscarawas officers for the 1972-73 year are: Mrs. Hamilton, president; Mrs. R. L. Gerber, president-elect; Mrs. L. L. Appel, vice-president; Mrs. Donald Mastin, secretary; and Mrs. Dale Kollman, treasurer.

Help Wanted!

This is my own personal SOS to county auxiliaries: Please get your news stories, your newsletters or ANY kind of information on what your auxiliary is doing to me (my address is listed at the top of this column). Send it in each month, if you can; if not, as often as you can! BUT PLEASE KEEP ME INFORMED! (How else can I do my job?)

Ohio Genetics Program Reports Initial Progress

The Ohio Training Program in Genetics of the Ohio Department of Health completed its first three months of operation in June 1972 and has been extended for another year, reports Dr. George Shadle, director of the Maternal and Child Health Division of that Department.

The program involves weekly workshops in principles of genetic counseling held at the Columbus Children's Hospital. The workshop core curriculum includes principles of inheritance and examples of inherited disorders such as sickle cell anemia, syndrome identification, chromosomal syndromes and principles of and practical experience in genetic counseling.

Among those instrumental in carrying out the program are Dr. Bruce D. Graham, chairman, Department of Pediatrics, Ohio State University College of Medicine and medical director, Children's Hospital; Dr. Stella B. Kontras, professor of pediatrics and director Genetics Division; Sally Murray, R.N., nurse specialist in genetics; and Alberta Morgan, R.N., nursing consultant, Division of Maternal and Child Health, Ohio Department of Health.

Drs. Shadle and Graham indicated that the program was addressing itself to a top health priority in Ohio, that of genetic disorders including sickle cell anemia. The workshops have stimulated enthusiasm among professional personnel in Ohio for recognizing and counseling in inherited diseases. Workshop participants have included public health nurses, pediatric nurse associates, social workers, physicians and medical students.

A two-day conference on Sickle Cell Anemia in June 1972 culminated the first phase of the program. A two-day conference on Genetics in Clinical Practice is in the planning for April 1973. Some phase of the program has reached close to 500 professionals and local seminars are being planned in various Ohio locales.

Additional information and applications may be obtained by writing to: Alberta Morgan, R.N., Nursing Consultant, Division of Maternal and Child Health, Ohio Department of Health, P.O. Box 118, Columbus, Ohio 43216.

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EMERGENCY, INDUSTRIAL and/or COMMUNITY Medicine. Established southern Ohio group seeks associates with any or all of the above interests. Full or part time positions available. Ohio license required. Medical Health Services, Inc. 3801 Hauck Rd., Cincinnati, Ohio 45241 Ph. 563-1505.

EXCELLENT OTOLARYNGOLOGY PRACTICE available October, 1972, in Lakewood, Ohio. Doctor retiring. Ideal layout with three examining rooms in modern one-story medical building. Furniture and equipment excellent. Good parking. Lease-rental very fair. Three large modern hospitals nearby. Contact: Dr. George W. Metz, 15700 Madison Ave., Lakewood, O 44107.

OVERWORKED SOLO OB-GYN. LOOKING FOR ASSOCIATION in Columbus or vicinity. Only request: at least eight weeks vacation per year. Available September, 1973, or join me at my present location under same condition plus 50% income sharing first working day. Reply: Box 659, c/o Ohio State Medical Journal.

RETIRING UROLOGIST has complete seven rooms of urological equipment and furniture for sale, excellent condition, consisting of two Young urological tables with G.E. head, resectiscopes, endoscopes and cystoscopes, etc. Dr. J. K. Nealon, 843 N. 21st Street, Newark, O. 43055; Phone (614) 366-1414.

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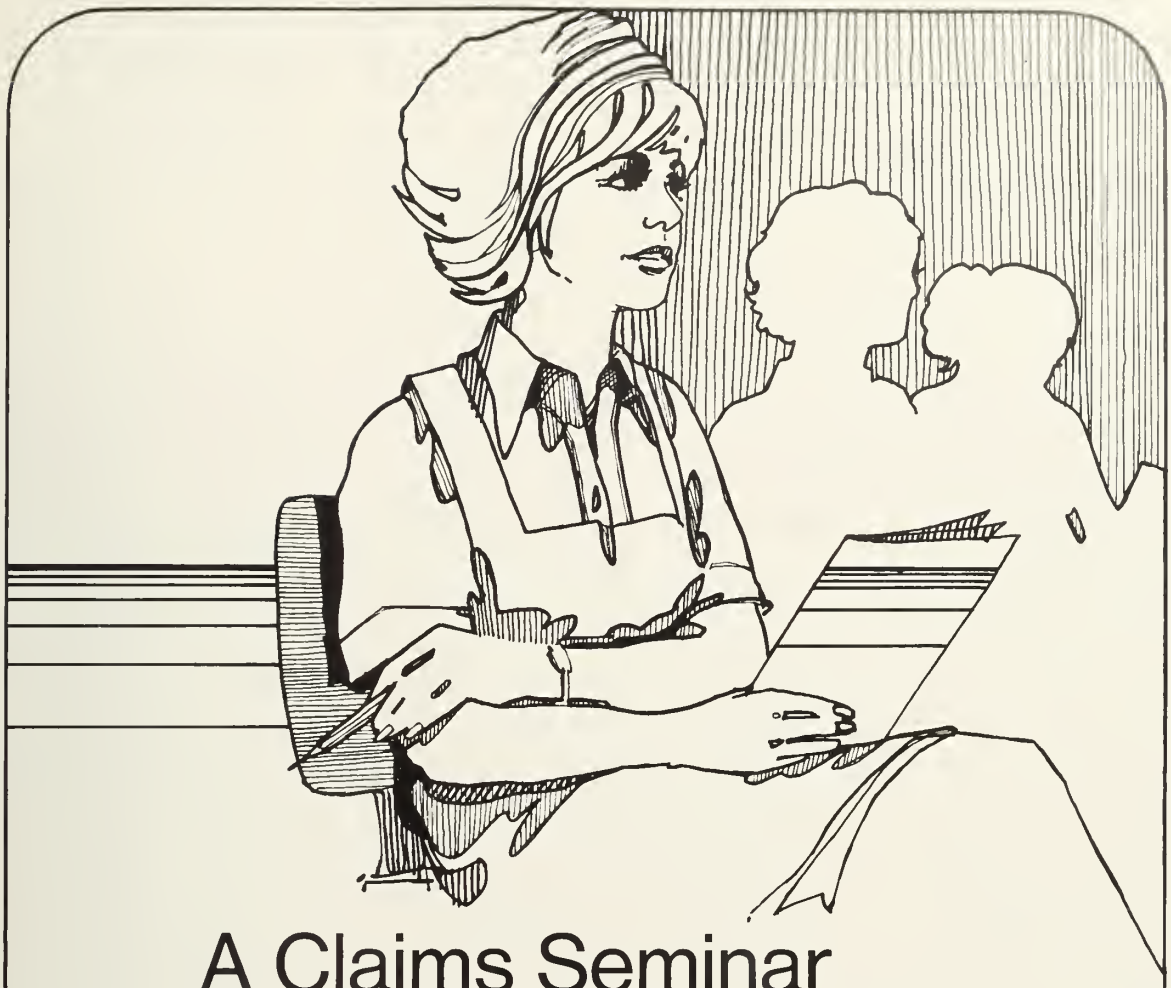
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VOL. 68 NO. 12

BOSTON
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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

I heard the bells on Christmas Day
Their old, familiar carols play,
And wild and sweet
The words repeat
Of peace on earth, good-will to men!

LONGFELLOW





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XCHANGE OFFICE
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MDs in the News

Dr. Robert M. Zollinger has announced that he will retire in 1973 from his positions as professor and chairman of the Department of Surgery at Ohio State University. Dr. Zollinger has been honored numerous times locally, nationally and internationally, especially for his contributions to medicine, surgery and education. He will continue his private practice.

Dr. Lawrence J. McCormack, of Cleveland, was elected to a three-year term on the Board of Governors of the College of American Pathologists during the College's Fall Meeting held recently in San Francisco.

Dr. Dale E. Fox, of Cincinnati, was elected Grand Master of the Grand Lodge, Free and Accepted Masons of Ohio, at the organization's recent convocation in Columbus.

Dr. William A. Altemeier, of Cincinnati, was elected to the Executive Committee of the American College of Surgeons at the organization's recent annual clinical congress held in San Francisco. ACS governors in Ohio are Dr. Altemier, for the Cincinnati area; Dr. James E. Bennett, Cleveland; Dr. Ewing T. Boles, Jr., Columbus; Dr. William D. Holden, Cleveland; Dr. Zeph J. R. Hollenbeck, Columbus; and Dr. Franklin L. Shively, Jr., Dayton.

Dr. George A. Sudimack has been named Warren health commissioner on a part-time basis. He will continue in his capacity as medical director of the Packard Electric Division of General Motors. As health commissioner, he succeeds Dr. Moses T. Knappenberger who died in August.

Dr. Byron E. Neiswander, was the subject of a feature article in the *Akron Beacon Journal*. After nearly 40 years of practice in the Doylestown area, he has taken down his shingle.

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Public Health in Ohio

By John W. Cashman, M.D.
Director, Ohio Department of Health

LADIES AND GENTLEMEN, welcome to the 53rd annual conference of Ohio Health Commissioners with the Ohio Department of Health. This Department isn't the same organization it was the last time we met. Change is taking place. We have new ideas, new people, and new programs. We are getting geared up to do an outstanding job for the citizens of Ohio. It's been an exciting 12 months since our last meeting and I've got a lot to tell you.

To combat communicable disease, we are constantly making complete immunization services readily available to more people. Last year approximately 150,000 children were immunized against rubella and measles. Our goal for the coming fiscal year is to immunize 300,000 preschool children against rubella and measles, 150,000 preschoolers against polio, and 100,000 against diphtheria, pertussis, and tetanus.

As part of our immunization program, we propose to educate and motivate parents of children of preschool age to have their children immunized either by a private physician or local health department. We want to develop a dynamic preventive health awareness program designed to educate and motivate the population on the necessity of complete immunization of all children during the first two years of life.

We are developing a statewide surveillance system capable of providing immediate and accurate information on the incidence of measles, rubella, polio, diphtheria, pertussis, and tetanus. In connection with the surveillance activities we will have an outbreak control system capable of responding within 24 hours to control an outbreak.

Accent on VD Control

On the subject of communicable disease, gonorrhea edged upward to a high of 30,713 cases for an increase of 6.2 percent over the 28,925 reported for the preceding 12 months. On the other hand, infectious syphilis dropped to 380, representing a decrease of 14.4 percent when compared to the 444 for the previous year.

Funding of an effective gonorrhea control program will enable us to intensify and expand gonorrhea control efforts throughout the state. The major thrust of our program will be to identify females with untreated gonorrhea and to provide treatment. Primary emphasis will be directed to major cities where more than 75 percent of the infections are reported. Through support provided to local health departments, we plan to culture approximately 600,000 females for gonorrhea and to interview for contacts those male gonorrhea patients who volunteer to public clinics. Private physicians and other health providers will be contacted and encouraged to actively participate by culturing for gonorrhea all females of child bearing age. Intensive educational programs will be conducted to motivate infected individuals to report for examination.

To effect a further reduction in syphilis infections, rapid and effective epidemiology will be applied to each infectious syphilis patient, and through the reactor surveillance program individuals with untreated syphilis will be referred to appropriate medical evaluation.

Other Programs

Through the first four months of the year the incidence of rabies in Ohio was occurring at more than double the previous year's rate. However, June and July saw a dramatic decrease in rabies cases so that now we are a little behind the 1971 total for the same period. This is due to the organization of special rabies clinics for pets in more than 20 counties.

In spite of the fact that rabies immunization clinics were very successful this year, there is still a need for legislation to establish canine rabies immunization on a permanent and uniform basis throughout Ohio. We intend to ask the General Assembly for such legislation during the next session.

Rheumatic heart disease remains the most preventable of the heart diseases and the continued drug prophylaxis for the prevention of secondary attacks through the local rheumatic fever registries has probably been one of the most important factors in the decline of deaths from

Report presented before the 53rd Annual Conference of Ohio Health Commissioners with the Ohio Department of Health, Columbus, September 13, 1972.

this disease in Ohio. We believe that the mail-in throat culture service for the identification of those with Group A strep infection and followed by appropriate treatment has been a most effective program.

We are now giving more emphasis to our education program on smoking and health. We hope to involve more young people and plan to distribute anti-smoking literature to Ohio school systems. We have been working with the drug education division of the Ohio Department of Education to inform educators about new curriculum materials on drugs, alcohol, and tobacco being developed by the Educational Research Council.

In the area of maternal and child health we have made progress in the development of family planning and getting local units to write projects for federal money. Almost all of the Ohio counties now have some form of family services funded by formula grants. Most major cities in the state have been funded for family planning projects.

Our Division of Maternal and Child Health is moving to spearhead an attack on sickle cell disease. A 10-member ad hoc advisory committee has been created. It includes both black and white physicians who are knowledgeable in this field. This committee has suggested that our MCH Division stimulate and support local groups in the development of programs and services. We know of approximately 25 sickle cell awareness groups in the state at this time. We are setting up training workshops to prepare qualified persons for counseling about the disease.

The number of alcoholism centers in Ohio has increased during the past 12 months from 29 to 34, with another six planned for this fiscal year. Our Alcoholism Program has been allotted almost one and one-half million dollars by the National Institute of Alcohol Abuse and Alcoholism, and state appropriations have been increased to $1,350,000.

Fluoridation Program

Since the passage of fluoridation legislation, all but seven of the 20 communities required to fluoridate their water supplies by January 1, 1971, have complied with the law. Canton, Columbus, Cincinnati, Dayton, Cuyahoga Falls, Piqua, and Montgomery County have not yet fluoridated their water systems.

Approximately 42,000 elementary school students in 88 schools located in low fluoride areas in 29 counties participated in a comprehensive dental health program conducted by our staff during the school year. In addition to group instruction in oral hygiene and preventive dentistry, 5,524 children were given each a dental examina-



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tion, an oral prophylaxis, a toothbrush, and a topical application of accidulated fluoride phosphate. Local health services reports indicate that school dental health and education program activities resulted in dental screening examinations for 104,294 students.

A Look at Institutions

Local health departments have been interested and cooperative in helping us to set up and sponsor classes for food service personnel designed to improve the nutritional care for residents in nursing homes, hospitals, and child care facilities. In-service education to update and keep the nursing staffs of local health departments current on nutritional care is an important activity of this Department. Twenty-three local health departments have received this service since our last conference.

We plan to ask the Public Health Council to approve some changes in regulations on nursing homes. These changes would provide for immediate steps to institute measures of safety by requiring fire drills, training of personnel, and a moderate increase in staff, especially during the night tour of duty. Also, we plan to appoint an ad hoc nursing home advisory committee composed of multiple disciplines to review all licensing requirements and to propose recommendations for updating present standards.

With regard to medical facilities, we have a new Hill-Burton program that provides financial assistance for the construction of neighborhood health centers with top consideration going to poverty areas. These centers are to be affiliated with a local health department or a general hospital to provide assistance in conducting clinics.

We have placed a high priority on the passage of a hospital licensure law for this state and a certificate of need requirement to provide guidance for the orderly expansion of needed hospitals and related medical facilities.

There are 12 federally funded migrant health projects in the state which provide a wide range of health services to migratory seasonal farm workers and their families. Eligibility for services has been extended to those who are leaving the migrant stream and settling in the state. A major portion of the medical care provided is in the evening family health service clinics in Darke, Hancock, Henry, Huron, Lucas, Mercer, Ottawa, Sandusky, Seneca, Stark, and Wood Counties.

This year in partnership with local health departments we have inspected 643 migrant labor camps. The great majority of growers have complied completely or partially with our recommendations. With the continued cooperation of health commissioners and the growers we will be able to provide decent housing for the migrant population.

A community environment resources unit has been formed in the Sanitation Division. In addition to factors in the natural and biological environment that have traditionally been important in the prevention of disease, this new unit will study and place emphasis on factors in the man-made physical environment and the socio-cultural environment. We will be using local health departments as entry points into communities for this unit to reach out and utilize community groups to resolve deficiencies in the physical and social environments which contribute to poor health.

A First for Ohio

We are entering into what we think will be a very worthwhile program in food service sanitation. That program is the certification of food service administration and management personnel after they have completed a rigorous and intensive course covering the various aspects of food service sanitation.

Ohio is the first state to include such an activity in a food service sanitation program. We do this as a result of recommendations from national food sanitation conferences and upon recommendation of the Ohio Food Service Advisory Board. We have already been in contact with many of you concerning our hopes and plans for this activity. Also, we have contacted many responsible members of the food service industry. I am pleased that all responses have been enthusiastic and responsive.

The quality of local radiological health programs continues to improve, and we like to think that training opportunities available to your personnel through our Radiological Health Unit is one reason for this improvement. State and local personnel have inspected 1,166 medical and dental facilities using x-ray machines, 18 nonmedical facilities, and 30 operations where radium is used. Compliance with radiation protection regulations of the Ohio Sanitary Code continued to reduce public exposure to radiation.

Our Bureau of Laboratories functioning through the central laboratory and three branch laboratories performed nearly 775,000 examinations in 1971, which represents nearly a ten percent increase in work load. Most activity areas included microbiology, environmental chemistry, industrial chemistry, clinical chemistry, metabolic and hereditary diseases chemistry, the Ohio Laboratory Improvement Program, and the Alcohol Testing, Approval, and Permit Program.

Gonorrhea culture activities have increased tremendously during the past 12 months, probably because of increased awareness and activities of family planning and planned parenthood clinics. We estimate that this will continue to increase as a result of the statewide gonorrhea culture project and the family planning gonorrhea culture project. Plans include more quality control of culture media and training courses for local laboratories engaged in this activity.

We are most pleased with the progress of our Ohio Laboratory Improvement Program. The laboratory training activities included monthly one-week courses in membrane filter water bacteriology, a course in syphilis serology and one in gonorrhea culture techniques, and two courses in rubella serology. These courses were offered to laboratory workers active in hospitals, private and public health laboratories throughout Ohio. Future courses will include antibiotic sensitivity testing, enteric bacteriology, more gonorrhea culture training programs, and a three-day course in hematology.

Statistics

By now you all have had an opportunity to look over the Vital Statistics report for 1971. We mailed 750 copies to local health departments, voluntary agencies, libraries, universities, and interested persons. We are initiating a project to microfilm all birth certificates for the years 1908 through 1946 for security purposes. Original birth certificates since 1946 are on microfilm which is stored separate and apart from the original certificates.

The 10 leading causes of death remained relatively unchanged with respect to rank; however, while diseases of the heart, the number one killer, appear to be on the increase, the remainder of the leading causes appear to be either decreasing or remaining constant. The trend according to sex follows a similar pattern, except that for the past two years suicide has assumed the eighth place as a leading cause of death in males. It is not ranked among the 10 leading causes of death overall. The number of marriages and the number of divorces and annulments were the highest ever recorded in this state. They were 95,641 and 42,186 respectively, with corresponding rates of 9.0 and 4.0 per 1,000 population.

Local Needs

This Department provided direct health education services to 40 local health departments. Ten counties had public health levies on the ballot last November. Five were successful and five failed. New levies or a renewal plus an increased percentage of a mill were involved in the counties



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where levies passed. New additions to our Health Education staff will make it possible for us to produce more radio and television programs for local communities.

We continue to receive numerous applications for political subdivisions for funding of ambulances and communications equipment. We have approved funding for 125 ambulances to date. Our largest project was the funding of ambulances and communications equipment for a seven-county Appalachia project.

Accident prevention and control of injury should be recognized as one of the most urgent of our environmental concerns. The protection of the total well-being of the human body is our responsibility as public health professionals. This protection includes the freedom from harm due to accidents as well as from disease. We try to promote safety and accident prevention through the use of films, slides, literature, and news releases distributed by our Accident Prevention Unit.

Environmental Health

Among the activities of our Office of Comprehensive Health Planning are priorities in the field of environmental health. The first priority reviewed and recommended by the Ohio Health Planning Advisory Council was the adoption of a proposal for solid waste management. A second priority that also went through the review and comment process was in the field of air quality management. Also, I'm pleased to report that the Health Planning Information System in the Office of Comprehensive Health Planning has been in operation since February of this year.

I'll finish up my report by talking about the Bureau of Environmental Health, that part of our Department which will soon become the Environmental Protection Agency. Last February we established a new position, that of Deputy Director for Environmental Programs. Dr. Ira Whitman was appointed to fill the position. Dr. Whitman, who came to the Department from the Battelle Memorial Institute, is charged with planning and overseeing the implementation of all programs concerned with the environment. He is an engineer and received his doctorate in environmental planning from Johns Hopkins University.

During the past year the Water Pollution Control Board held three significant hearings. In August of 1971, a hearing was held on proposed water quality standards for the Mahoning River. In September of last year a hearing was held to upgrade the general water quality criteria. Last April, we held a hearing to revise the implementation schedules for the upper Ohio River moving these ahead two years to 1975 instead of 1977 for completion of secondary treatment devices.

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In the water supply field, we approved plans for new and improved water supply works amounting to more than $39 million during 1971. The Ohio Public Health Council has adopted new cross connections and back-syphonage control regulations. Also, you may have noticed or been involved in the enforcement of regulations requiring fluoridation of public water supplies serving more than 2,000 persons.

The staff of the Air Pollution Control Unit is now in the process of implementing the permit portion of the state air pollution control regulations. This will involve at least 25,000 sources of air pollution control. It has been determined that there will be one centrally directed statewide control program and that the dozen or so local agencies now in operation will be delegated authority by the state to participate in the program.

In the solid wastes field, we have approved plans for 39 projects for new disposal facilities worth $4.5 million. We are in the process of expanding our solid waste staff and will be giving more attention to recycling possibilities and to ground water problems which may result from landfill operations.

While on this subject, this may be a good opportunity to say farewell to our friends in the Bureau of Environmental Health. As you probably know, next month most of the people in these divisions will be transferred into the new Environmental Protection Agency. I'm sure Dr. Whitman knows we wish him and the members of his staff the best of luck.

Finances

The local health departments, both city and county, spent $29,402,793 during fiscal year 1972. Included in this amount was $1,083,038 federal formula (314-d) funds and $1,229,579 maternal and child health federal formula grants. State subsidy payments to local health departments remained at $420,000 for 1972.

The expenditures for general operations of the Ohio Department of Health totaled $1,851,-794. This includes the publication of literature, purchase and distribtution of drugs, vehicle maintenance, accounting, and cost of grants management. Total expenditures of the Department were $36,490,864.14, of which $30,308,988.97 represented federal funds, and $6,181,875.17 came from state of Ohio funds. We were able to attract four federal dollars for each state dollar.

I might point out that 47 percent of our budget went for medical care administration, and 31 percent was for community health programs. This is an overall 78 percent for programs that provide direct service.



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SPECIAL ARTICLE

The Physician: Dedicated, Skillful, Responsible And Respected

JOHN H. BUDD, M.D., CLEVELAND

IT is a very great pleasure for me to be here with you in this most beautiful part of our country, and to bring to you greetings from the officers and Board of Trustees of the American Medical Association. Of all the assignments given Board members, none is more eagerly sought and accepted than being delegated to attend the West Virginia State Medical Association's Annual Meeting here at The Greenbrier.

The AMA Board feels strongly that visits by officers and Trustees strengthen the bond between us all—between the central core of our organization and the state and county medical societies, as well as between individual physicians. We hope to improve communications; become better acquainted with your problems; tell you about some of us; ask how we might help you, and learn what you might offer to help us.

One of our mutual problems—or, at least, it has been charged that we have such a problem in serious degree—is that American physicians have a bad public image. Certainly our established system of medical practice, and we physicians who engage in it, are being clamorously criticized from many quarters: the public, the news media, some legislators and from within the profession itself, including some of our colleagues in positions of authority.

This criticism, much of which is actually defamation, strikes a sensitive nerve in me and I'm sure it does the same to you. As a physician, I regard the performance record of my profession and my colleagues with pride and without arrogance. When I feel maligned, I don't want to be considered paranoid. However, before we become despondent, merely mutter "mea culpa" and run scared, accepting—and even snatching for—every new plan and proposed change in the system, we should bear in mind a few facts.

Criticism

First, as targets of criticism, we share the stage with preachers, professors, presidents (including our country's President), politicians and many others—certainly not an undistinguished group (Former President Truman made a perceptive comment about kitchens and the heat).

Second, criticism is frequently unjustly spotlighted on areas of weakness and imperfection which are small—though not trivial; and by generalization it is implied, if not asserted, that these deficiencies are typical. The Columbia Broadcasting System warns, "Don't get sick in America." This production, allegedly a documentary, was in reality an editorial in support of compulsory government medicine. A columnist wrote that you can't get a doctor when you need one; that thousands of small towns have no doctor; that 20 million Americans have no regular access to medical care. By inference, 180 million *do* have such access; and as Dr. Russell Roth, the AMA President Elect, has said on numerous occasions, "More people are receiving more medical care from more and better doctors, in more sophisticated facilities than ever before." Doctor Roth is correct. Obviously, while the goal of complete access to needed care for everyone has not yet been realized, both availability and quality are improving. Like Avis, we must try harder, but we should never be ashamed of our performance.

Third, we should take heart from the results of a Harris Poll (noting, too, that Mr. Harris is free from built-in, pro-physicians bias). The poll was evaluating public respect for leadership in various walks of life in the United States. It found that such respect had "dropped drastically" in the last five years, and declared that out of a list of 16 different types of activity, the only vocation in

The author is a practicing physician in Cleveland and a member of the American Medical Association Board of Trustees. This article is the text of a presentation before the West Virginia State Medical Association at The Greenbrier, White Sulphur Springs, August 23, 1972.

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which more than 50 percent of Americans were willing to express "a great deal of confidence" was the medical profession. Ranking lowest in public respect were leaders in advertising, trade unions and the mass media.

In a similar poll assaying truthfulness and public trust, conducted at the University of Connecticut, you might be interested to learn that TV news reporters' reputations for honesty exceeded that of plumbers, though only by a notch (11th vs. 12th in the roster). TV repairmen ranked above newspaper columnists (15th vs. 16th); labor union officials were more trusted than politicians (18th vs. 19th); and at the bottom of the list of 20 were used car salesmen. You might be further surprised—I know you will be pleased—to hear that leading the entire list in credibility were physicians.

The Industrial News Review, quoted in the Milwaukee South Times, commented appropriately and comfortingly, "It seems that in spite of any efforts to create mistrust of the nation's doctors, the people still look to their physician as a man to be respected. In today's world of cynicism and distrust, this is indeed a high tribute to the integrity of the profession."

Finally, although the wage-price controls imposed on physicians were extremely discriminatory, the cooperation of the profession was well evidenced by the fact that, according to data published by the Federal Bureau of Labor Statistics, physicians' fees increased only 1.37 percent during the first nine months of the Economic Stabilization Program. This was true while the Consumer Price Index rose 2.05 percent, and the semi-private hospital room went up 3.84 percent.

Our AMA President, Dr. Carl Hoffman, accurately commented, "These figures prove that physicians—largely through self-imposed restraint—have made a major effort to help stem inflation." Most important, he added, "it should be noted, however, that physicians' fees are only a very small factor in the over-all effort to control inflation."

Yes, physicians can take pride in the record and reputation of the profession. Satisfaction, however, cannot be complete. Remember that "self-conceit may lead to self-destruction." We will do our best to maintain quality of care, improve accessibility and control costs, realizing there are limits to our capabilities in these areas, too. Over-promising of immediate delivery of unattainable objectives is a major cause of the turmoil and upheaval that we have been witnessing around us today—not just in health matters, but in education, housing, civil rights, crime control, elimination of poverty, etc.

Self-analysis and self-discipline through the mechanism of peer review make up the hallmark of an honorable profession acting responsibly in the public interest. I believe in it sincerely, and would only like to see it applied more widely—say, in industry, labor unions and Congress.

One factor beyond our accountability is inflation, probably the biggest element in increasing costs. In line with what I have just said, I'd hope that legislators, in their efforts to control inflation, will exhibit physician-like dedication as they attack this obvious government responsibility.



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Women Doctors Past, Present and Future

Frances Keller Harding, M.D.

THE POSITION OF WOMEN in the field of medicine is passing through an interesting change during the eighth decade of the twentieth century. The manpower shortage, the powerful forces of social change operating in our society and the emancipation of women from a restricted opportunity for a career of her choice to full participation in the life of America has focused mass attention upon our educational facilities and system. In this milieu an amazing interest has been generated in the professional training and opportunities for women in medicine.

The past has always shown some involvement of women in the healing art. The early historian Josephus[1] mentions women physicians centuries ago, Wickersheimer[2] recalls many prominent Jewish women doctors in France during the thirteenth and fourteenth centuries. Women physicians were recognized throughout most of the known history but suffered the anonymity accorded women as the weaker sex, the mothers of the future of the race and the property of the man to whom she was married.

The Geneva Medical College of New York State in 1849 conferred the first M.D. degree on a woman who had done her medical training in the United States. Her application for admission had been received by the faculty and student body. Their first impression and comment was, "As crazy as a man thinking he could become a Mother." She was not permitted to attend all of the classes for certain subjects were taboo in the presence of a lady. Even the professors stuttered when, in the course of their lectures, the word *sex* became necessary as a factor in the subject being presented. The demure Quaker girl won the hearts of the faculty and student body to go forward to an outstanding career in medicine.

One year later the first and only medical school exclusively for the education of women students was founded in Philadelphia. Established under the name of "The Female Medical College of Pennsylvania" the name was changed in 1867 to "The Women's Medical College of Pennsylvania." One hundred three years later as a victim of the nondiscrimination policy of the present era it changed the name to "Medical College of Pennsylvania" and opened its admission doors to male applicants. This school has graduated 40 to 50 women physicians each year in recent decades. In 1972 the first male graduates completed their medical studies. In contrast to the other medical schools, the Medical College of Pennsylvania is domonstrating its sincerity in the antidiscriminatory program by seeking to attain a fifty-fifty, men-women ratio in the student body by 1980.

I am personally involved in the status of women in medicine by being a member of a three-generation-of-women-doctors sequence, all three of whom have been married to physicians. My mother began practice in 1900 and my daughter could easily continue in practice until the beginning of the twenty-first century.

As a young doctor my mother was denied the opportunity to sit a state board examination merely because she was a woman. Thirty-five years earlier a woman applicant to a sister state had been rejected, at which time the editor of the medical journal of Australia wrote: "If Winifred Ferguson favorably impressed our legal experts she produced quite the opposite effect upon the medical profession. The application comes from America where women insist on doing what is done for them in less advanced communities—and a woman who voluntarily devotes herself to a state in which the abandonment of the domestic qualification seems a necessity, is a being whom men do not love and with whom women can hardly sympathize . . . . But there is little fear that in any British community medical women will exist as a class. They will occasionally be imported as a class like other curiosities, and the public will wonder at them just as it wonders at dancing dogs, fat boys and bearded ladies. And in accordance with the demand for novelties they will, perhaps be as successful in a material sense, but they are not likely to be included in the list of British Institutions."

With such an attitude facing them, is it any wonder that many of her colleagues felt com-

Dr. Harding is a practicing physician in Columbus and the 1971-1972 President of the American Medical Women's Association.

pelled to wear a costume closely resembling a man's clothing in order to minimize the sex identification in her professional work, opportunities in hospital service, medical society association, faculty appointments and jobs. In the first place these opportunities were not extended to them in an enthusiastic manner and to obtain a grudging entrance to them often required aggressive action which was not always pleasant in any manner.

Today the situation is not so abrasive. The medical schools are beginning to admit women on a more liberal scale. The male doctors are graciously accepting women as a portion of their peer group. Indeed, they have acknowledged certain women such as Maud Slye in cancer heredity, Gladys Dick in scarlet fever, Florence Sanin in hematology and H. Taussig in cardiac surgery to be outstanding authorities in their fields of interest.

In the world view, the United States with its vaunted progressive attitude has only more women physicians percentagewise than Spain, Madagascar and South Vietnam.[3] Other countries having a larger percent of women go as high as four times the proportion that America has. If we can believe the figures, we are told that Russia has 70 percent of its doctors in the female category. In view of this the seven percent in the United States does not appear enough. The rapid increase in medical schools from 89 to 108 from 1967 to 1972 with all of them admitting women to their student bodies is most encouraging. The last school to deny women admission to the course was Jefferson in Philadelphia which lifted its ban less than ten years ago. These facts accompanied with the increased acceptance rate gives assurance that women will have a greater representation in the future of the profession.

The statistics from the physician's master file kept currently by the AMA[4] reveal that 24,400 women physicians are registered in the United States of whom 83.9 percent are in active medical work. This compares quite favorably with the approximately 90 percent of the male registrants who are active in the professional life. In view of the longer life expectancy of women, these figures appear to refute the often used argument that the effort to give a medical education to women was a waste on the presumption that they will not use the knowledge in the care of the sick.

The majority of women practitioners are engaged in patient care activities. Their fields of interest in a descending order are pediatrics, psychiatry, family practice, internal medicine, anesthesiology, obstetrics and gynecology, and pathology. These seven specialties account for nearly 75 percent of all the women in practice. Thirty percent of all pediatricians are women and this specialty includes a thousand devotees more than any other specialty. A number of women are found in general and orthopedic surgery, plastic surgery, and two are qualified at last count in neurosurgery. The most isolated one is in the field of aerospace medicine. Obviously no field of medical activity is beyond the capability of women.

The geographical distribution finds women practicing in every State of the Union. Like their male counterparts they seem to prefer the more populous States and cities where living and social interchange are most pleasant. The 4,469 in New York State is the largest incidence in the entire land. In a descending numerical order the number decreases in California, Illinois, Pennsylvania, Ohio, Massachusetts to New Jersey recording 825 on their medical role. The 24 women physicians in Alaska constitute 12 percent of the profession in the fiftieth State.

The eighth decade of the twentieth century has shown many interesting and encouraging changes. At the AMA convention the delegates passed a resolution introduced by the Ohio State Medical delegation. In part the resolution reads, the Association and its component parts should "recognize professional, personal and civic qualifications of female physicians by electing or appointing them to policy-making committees within the Association." Wesley Hall, M.D.,[5] President of the AMA, stated in reference to women doctors, "We need more of them and that is an official statement made by the AMA at our convention last June" (1971). This year the OSMA has demonstrated sincerity by placing women members on nine of the Association's regular committees.

Optimism has been generated by the increasing requests for women physicians to occupy upper echelon positions in the National Institutes of Health and in the Health, Education and Welfare programs. Requests have come from the White House for names of suitable women for a multitude of positions. Numerous colleges and Universities have asked similar assistance. These openings are able to give women an opportunity for high responsibilities commensurate with their capacity. Inured to mediocrity in times past by the market, this new acceptance is truly stimulatory.

Just as youth in general are the future hope of the nation so your daughters and granddaughters are the future components of women in medicine. Inspired by varying experiences one of them will eventually proclaim her desire to follow in your footsteps by becoming a physician. Immediately a series of devastating objections will

begin to almost overwhelm her. "It's a man's field." "You mean you want to be a nurse." "The course is long, difficult, expensive and bad for your health." "You would have to postpone getting married and could not have a family for too long a time." "We can't afford to put that much money into your education and still have enough to send your brother to college: after all, he is going to have to earn the living for a family." "Take something that is not so demanding."

Such observations could be protracted ad nauseam. These assaults come from parents, relatives, friends, teachers and even school counselors. It is all based upon outdated knowledge as well as prejudice. In recent years the deans of medical schools are encouraging girls to apply for admission to medical school. Part-time internships and residencies are being developed and already over one hundred are established. They are so structured that a woman doctor can cope with the family problems and still continue her postgraduate training, at an individualized pace. The cultural changes of the past decade have given women the freedom to pursue the career of their choice and it is no longer considered improper to aspire to be a physician and continue to be completely feminine.

Would it not be delightful if your daughter or granddaughter heard you say, "I think that is a great idea." "I would be so proud to see you a doctor like your dad." "It will require a lot of hard work and money for both of us but I will help you with the greatest pride and enthusiasm." "To get into medical school you will have to complete the required high school studies and college premedical subjects and make the best grades you can." "In high school take personal typing and bookkeeping for you will find this indispensable in later operating your office." "Study filing systems so that you can find certain facts that you need to recall." "These skills will not be of help in your practice alone but will serve you well during your college years." "In meeting your language requirement, study German, French, Russian or Japanese for these are the languages that are used most frequently in that order for the reporting of the results of scientific research." "In addition to the premedical

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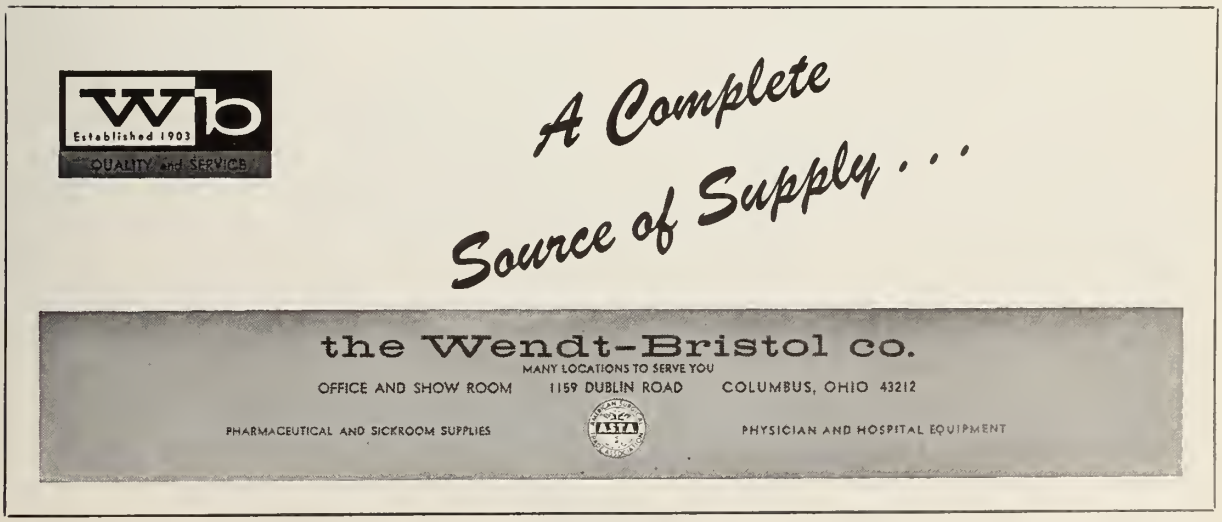
*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964.

core subjects you must remember that many medical schools require certain specific subjects that may differ from the average admission basis so investigate the demands of the schools that you are considering making application for admission." "In addition to the basic program fill your college years that are so full with an introduction to the humanities." "You will spend most of the rest of your life with science so get an introduction to art, literature, history and any other subject in which you have an interest or even a curiosity." "It is not too early to begin the development of skill in some hobby." "Among your interests in a hobby there must be a physical skill as well as an intellectual challenge." "The activities should involve both outdoor as well as indoor components." "Certain recreations require such a long period of time, involve too many other people or include environment that is not compatible with your professional activities, making them undesirable." "These interests, regardless of what you choose, will later serve as a refuge from the inevitable tribulations inherent in a busy practice of medicine."

In the next few years the programs we are now engaged in pursuing will have borne fruit. We anticipate that your child will meet a welcome such as her antecedents in the profession never enjoyed. First, there should be no restrictive quotas but an open policy of admissions based directly upon academic qualification. The admitting committee will have a woman member so that interrogators will not range into personal unrelated fields which are not applied to the male applicant. The curriculum will be organized in a track system making it possible for each individual to travel at a suitable speed depending upon the needs and personal responsibility of the student. The post college training programs will have a new structure so that part-time involvement or two doctors sharing a single appointment with relative lengthening of the time factor and remuneration will be available for the house officer. The fact that women will be accepted as an integral part of the profession without having to compromise their feminine nature will make medicine germane to their choice of a career. The time will come when the vast potential resources will be used by the people in meeting their medical needs.

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Head of Surgery Named President of Medical College of Ohio at Toledo

Marion C. Anderson, M.D., was elected president of the Medical College of Ohio at Toledo by the Board of Trustees at its October 16 meeting.

Dr. Anderson has been professor and chairman of the MCO Department of Surgery since he joined the new college in 1969.

As president he succeeds Dr. Glidden L. Brooks who served as MCO's first president during the college's formative years from 1966 to 1971.



Dr. Anderson

A native of Concordia, Kansas, Dr. Anderson holds three degrees including the M.D. degree from Northwestern University. He served his internship and residency in surgery at Passavant Memorial Hospital and the VA Research Hospital, both in Chicago. He became an instructor in surgery at Northwestern in 1958, and had reached the rank of associate professor when he left Northwestern to head up the surgery department at MCO.

Dr. Anderson has an international reputation for his work on pancreatitis. He is certified by the American Board of Surgery and is a member of many professional and scientific organizations including the American College of Surgeons, American Association for the Advancement of Science, Association of American Medical Colleges, and the Society of University Surgeons, as well as the American Medical Association, Ohio State Medical Association, and the Toledo Academy of Medicine.

Since coming to Toledo, Dr. Anderson has become a charter member of the Toledo Surgical Society and served as president of the Society for two years. With the late Dr. Keith Welborn, he played an important role in forming the Northwest Ohio Council on Emergency Medical Care.

His curriculum vitae lists 87 published articles, seven books and 56 unpublished scientific reports and presentations.

MCO Trustee Thurman W. Bretz, of Toledo, was chairman of the eight-member search committee appointed in 1971 to find a successor to Dr. Brooks. In recommending Dr. Anderson for the presidency, Mr. Bretz praised his "acceptance of extraordinary responsibility . . . and great capacity for leadership" during the period the college has been without a president.

In addition, said Bretz, Dr. Anderson "has served tirelessly in the formation of his department, the furtherance of the school as a whole, and on behalf of medical programs throughout northwestern Ohio."

Rural Health Conference Scheduled in Dallas

The 26th annual National Conference on Rural Health, sponsored by the American Medical Association's Council on Rural Health, is scheduled to be held in Dallas, Texas, Thursday and Friday, March 29-30. The Statler-Hilton is the headquarters hotel.

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"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

–George Sarton, from "The History of Medicine Versus the History of Art"

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion

Results of a questionnaire to 7,000 physicians:

62.9%
Believe combination drug products are useful.

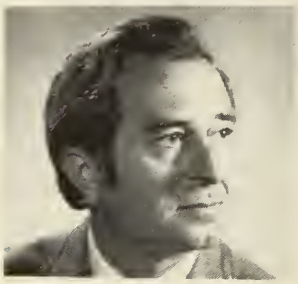
13.8%
Do not believe combination drug products are useful.

Are combination drug products useful in treatment involving concomitant use of two or more drugs?

Opinion & Dialogue

Doctor of Medicine

Louis Lasagna, M.D.
Professor and Chairman
Department of
Pharmacology & Toxicology
University of Rochester
School of Medicine
and Dentistry



Obviously, many drugs are given concomitantly. Whether it makes sense to combine medications in one preparation, he it capsule, tablet, or liquid, is a question that can be answered only by examining the advantages and disadvantages in the individual case.

Among the advantages is, first of all, convenience. The more medications that are taken concurrently and the more complicated the directions, the less likely the patient is to take medications accurately. From the standpoint of convenience and accuracy, and economy as well, you can make an important case for putting medications together in one preparation, as long as they are compatible.

By the same token, when you prescribe a properly tested and rational combination, you should have less worry about pharmaceutical or pharmacological compatibility – and about reasonable dosage ratios as well. Compatibility of the formulation should be demonstrated in the laboratory and clinic before the product is available for prescription–which is more than can usually be said for the physician's own spontaneous creations. And, the dosage ratios employed in rational precompounded combinations are designed to meet the needs of substantial numbers of "typical" patients.

There is no doubt that many "atypical" patients are to he found, and for them the prefabricated combination must be rejected. But that hardly argues for eliminating rational combinations from the market. Think, for example, of the problems that would arise if the components of widely accepted combinations, like the oral contraceptives and the diuretic-antihypertensives, always had to be prescribed, purchased and ingested separately.

One disadvantage that comes to mind is some doctors' unawareness of the ingredients a given combination contains. For example, a doctor might know that a patient is allergic to aspirin hut forget that a certain analgesic mixture, which he knows only by its trade name, contains aspirin. His prescription, then, causes considerable discomfort, to say the least. This problem is a function of physician education, rather than of combination therapy as such. Improving doctors' knowledge about all medicaments they prescribe is a problem that deserves tackling on its own.

Another accusation leveled at combination drugs is that they encourage sloppiness of diagnosis and treatment. In many cases, however, a combination may prove to be the most effective choice. A good example of the usefulness of combinations appears in a recent article in the *Journal of Chronic Diseases* on the efficacy and side effects of an antihypertensive containing three ingredients, in which the track records of the combination drug and the individual ingredients were compared. Interestingly enough, whether the drugs were given individually or together, incidence and severity of side effects were the same. But blood pressure control was invariably better when the drugs were taken in one combination tablet than when they were taken separately (in "titratable" dosage) or in two or three different tahlets.

Deciding which combinations constitute rational therapy obviously leads to a discussion of who is to determine which should be used and which should not. Realistically, I think combinations should be evaluated somewhat differently if they are old and estahlished or new and untried.

In today's regulatory atmosphere, there is no possibility of a new combination being put on the market without a suhstantial amount of acceptable evidence in the form of controlled trials that show it to be safe and efficacious. On the other hand, I helieve a different set of standards should apply to combination preparations that have been around for a long time. In other words, physician acceptance over a long period should be given some weight as evidence of the efficacy and safety of these drugs.

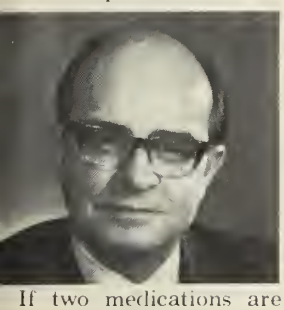
The FDA, however, does not seem to share this attitude. It often requires, for these older products, controlled trials that will monopolize the time of already overtired investigators and cost a greal de of money. I wish we cou agree on a "grandfath clause" approach to prep rations that have been in u for a number of years a that have an apparent satisfactory track record.

For example, I thi some of the antibiotic co binations that were tak off the market by the FL performed quite well. I a thinking particularly penicillin - streptomyc combinations that patie – especially surgical p tients – were given in o injection. This made t less discomfort for the p tient, less demand nurses' time, and few opportunities for dosa errors. To take such preparation off the mark doesn't seem to be go medicine, unless actual age showed a great deal harm from the injectio (rather than the prop use) of the combination.

The point that should emphasized is that the are both rational and ir tional combinations. T real question is, who shou determine which is whic Ohviously, the FDA mu play a major role in ma ing this determination. fact, I don't think it c avoid taking the ultima responsibility, but it shou enlist the help of outsi physicians and experts assessing the evidence a in making the ultimate d cision.

Maker of Medicine

W. Clarke Wescoe, M.D.
President
Winthrop Laboratories



If two medications are used effectively to treat a certain condition, and it is known that they are compatible, it clearly is useful and convenient to provide them in one dosage form. It would make no sense, in fact it would be pedantic, to insist they always be prescribed separately. To avoid the appearance of pedantry, the "expert" decries the combination because it is a fixed dosage form. When the "expert" invokes the concept of fixed dosage form he obscures the fact that single-ingredient pharmaceutical preparations are also fixed dosage forms. By a singular semantic exercise he implies a pejorative meaning to the term "fixed dose" only when he uses it with respect to combinations. What is ignored is the simple fact that only in the rarest of circumstances does any physician attempt to titrate an exact therapeutic response in his patient. It is quite possible that some aches and pains will respond to 500 mg. of aspirin yet that fact does not militate against the *usual* dose being 650 mg.

The other semantic ploy often called into play is to describe a combination product as rational or irrational.

Take antibiotic mixtures, the source of much of the criticism generated against combinations generally. Obviously, no one should be exposed willy-nilly to the potential side effects of two or three antibiotics when only one is needed. At the same time there are cases where it is prudent to prescribe more than one. The clinician is the judge in these circumstances, as he should be.

There is no clear definition of the word rational. Most persons, I suppose, would find it synonymous with reasonable, but in many circumstances it may best be defined as the opinion of those in power at the moment.

Other factors govern combination therapy, not the least of which has been its broad use by practicing physicians anxious to achieve convenience in prescribing, to reduce medication error, and to save money for their patients. Combinations clearly have met the test on all three counts.

I have been impressed by studies showing that the rate of error climbs markedly with the number of medications to be taken, even with sophisticated patients. When medically justified, therefore, this factor alone supports the logic of combination therapy.

The cost argument for combinations appears to be irrefutable. In 1971, R. A. Gosselin studied the 71 combination products (excluding oral contraceptives) among the 200 most prescribed drugs. The study found that if all 71 products were discontinued, and if each ingredient in these combinations were prescribed separately, the price of medicines to patients would jump by $443.2 million on a national basis! At a time when the cost of medical care is under so much fire, it would be nonsensical to boost costs without clearly irrefutable medical reasons.

The part played by government on this question, of course, is fundamental. The FDA should play a role in determining which combinations are reasonable. That role, as defined by law and regulation, is to ensure that any medication on the market is safe and effective in line with its label claims. Certainly combinations are entitled to as much consideration as single entities—neither more nor less. So long as the addition of one drug to another does not make either less safe, or less effective, so long as they are compatible in a formulation, we have a reasonable product. It makes no sense to recommend the use of two products for certain conditions and to deny their being combined in a single form. An unhappy side effect of the problem concerns the efficacy panel discussions of many products submitted for review. The term "effective, but" has been freely interpreted to mean "ineffective" in toto, regardless of the merit of the individual drugs. This interpretation has placed numerous useful combination products in needless jeopardy.

In reading the actual reports of the review panels, it seems clear that some of the ratings were based less on scientific research and clinical observation than on the "informed" opinions of the panelists. These "informed" opinions were accepted at face value, while the "informed" opinions of others who had used the products were rejected. All of this put combination products into a sort of scientific never-never land.

It should be kept in mind by all, government as well as others involved in our health care system, that advances in therapy are seldom made in leaps and bounds but rather by small painstaking steps—and that some of these steps have resulted from research in combination drugs as well as with single entities. Given the near-infinite biologic variation in patient response, this is hardly surprising to clinicians. It should not be to regulatory agencies either.

In the end, the practicing physician is in the best position to decide if a particular combination makes sense. Such a decision should not be made exclusively by those whose responsibility for continuing clinical care is limited. Clinicians are the best judges of efficacy because the ultimate proof of any product's effectiveness is acceptance by physicians who have observed its actions in patients over time. The corollary statement may be made about over-the-counter medicines, which would not long survive if they failed to afford the relief the user anticipates. That the antihistamine in a "cold" remedy may not *always* be necessary is no reason to proscribe the combination generally.

Opinion & Dialogue

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Clinical & Scientific Features



VOLUME 68 DECEMBER 1972 NUMBER 12

Stress Urinary Incontinence in the Female

The Role of Bead-Chain Studies in Diagnosis and Treatment

AMRUTHA B., M.B.B.S.*

STRESS URINARY INCONTINENCE (SUI) in the female is a problem that frequently confronts the gynecologist. Satisfactory results from treatment can be obtained consistently only when stress urinary incontinence can be differentially diagnosed from other types of urinary incontinence, viz, urge incontinence, overflow incontinence caused by dysfunction of the bladder, detrusor dyssynergia, and incontinence secondary to fistulae. Accurate history, physical examination, urinalysis, urine culture and sensitivity, certain blood chemistries, intravenous pyelograph, cystoscopy, cystometrogram, and urethrocystometry are all essential for a consistently correct diagnosis. In our institution, we believe that bead-chain urethrocystograms play a very significant role in (1) making a definitive diagnosis of stress urinary incontinence, (2) selecting the type of treatment in each case, (3) selecting the precise *surgical* approach if that is the treatment of choice, and (4) as a method of radiographic determinations in the postoperative period to see if the desired anatomic alteration has been achieved.

The Author

• **Dr. Amrutha B., Toledo, is Instructor, Department of Obstetrics and Gynecology, Medical College of Ohio at Toledo.**

In 1910, Cunningham[1,2] reported on roentgenologic visualization of the female urethra by means of contrast media. Since then various liquids, semisolids, and pastes have been used for the radiographic visualization of the female urethra[3,4] and bladder. Stevens and Smith,[5] in 1937, published the first article on the use of metallic bead chains as part of urethrocystograms.

This was followed by many articles on this technic by various authors. Over the years, significant gains in the interpretation of bead-chain urethrocystograms have given us insight into the mechanics of the bladder and urethra in the maintenance of urinary continence. Hodgkinson

*The author's name given above is as it is customarily written in her native India. In the *American Medical Directory* and other documents, her name is listed as Amrutha Bhakthavathsalan.

Submitted May 5, 1972.

has summarized the current literature very well in his articles in 1965[3] and again in 1970,[6] and he pointed out that use of metallic bead chains improves the quality of urethrocystograms. The advantages are: (1) easy visibility, (2) the distinct outlining of the urethra and posterior bladder, and (3) their pliability avoids any splinting of the urethrovesical structure but does accommodate readily to the varying relationships of the urethra and bladder.[2]

Technic

Bead-chain studies are always supervised by the gynecology resident. The procedure is explained to the patient. After voiding, she is placed supine on the x-ray table. Following Zephiran preparation of the area, a 5-in metallic bead chain is introduced into the bladder by a hemostat until 1 to 1½ inches of the bead chain is left outside the external urethral meatus. A #12-14 rubber catheter is then introduced into the bladder while maintaining the bead chain in position. The bladder is drained of any residual urine, noting the volume. Approximately 150 cc of radiopaque solution (60 cc of Renografin plus distilled water) is slowly introduced into the bladder. The catheter is carefully withdrawn. The table is tilted upright. Anteroposterior and lateral films are taken, first nonstraining, then straining. It is important that the nonstraining films be taken first. The altered anatomy during dynamics of straining does not easily revert to nonstraining position and thus may adversely effect the quality of the next nonstraining film. Films are developed and viewed immediately, and if they are satisfactory, the chain is removed, and the patient is allowed to void.

Interpretation of Bead-Chain Urethrocystograms

Stress urinary incontinence is defined as loss of urine in spurts with increase of intra-abdominal pressure such as coughing, sneezing, etc. Detrusor contraction is not involved.[3]

As a result of adoption of the erect posture in the human female, the pressure exerted by the total column of the abdominal organs is constantly acting directly upon the bladder. Continence under these circumstances is dependent upon the spatial relationship of the bladder and urethra at the region of the bladder neck. Lateral urethrocystograms are the most valuable in determining this relationship.[2,7] In the anteroposterior views, the bladder neck region may be obscured by a posterior bladder that descends to a plane lower than the urethrovesical junction — eg, with cystocele (Fig. 1). In the continent female, in the resting phase, the bladder base is



Fig. 1. Anteroposterior view of large cystocele obscuring the PUV angle.

about at the level of the middle of the symphysis pubis and the urethra takes off from the bladder at an acute angle of less than 90°. Roberts and Jeffcoate,[7,8] call this the posterior urethrovesical angle (PUV angle). On straining, there is slight descent of the bladder but the PUV angle is essentially maintained and is not lost until the process of micturition is initiated.[9]

In stress urinary incontinence (SUI), on straining, the PUV angle is more than 90°, completely lost, or even reversed depending upon the severity of the condition (Fig. 2). That is, the radiologic appearance on straining is similar to that seen during micturition in the continent female.[9] What appears as a sharp angle when catheters are used for a urethrocystogram becomes more of a smooth curve when bead chains are used. However, as Hodgkinson points out,[3] the interpretation is essentially the same. As long as the urethrovesical junction is at a higher level than the bladder base (as is the case with PUV angle of less than 90°), the brunt of increased intra-abdominal pressure is borne by the posterior bladder, but when the urethra takes off from the most dependent portion of the bladder (as in loss of PUV angle), the brunt of maximum hydrostatic pressure falls directly on the internal meatus causing urine to be lost.[3,6] This concept explains why a female with uterovaginal prolapse and marked cystocele can still be continent. Her urethrovesical junction is relatively higher than her posterior bladder (Fig. 3). In this patient, following anterior colporrhaphy with very good anatomic results and with "the bladder very well elevated," SUI may actually develop after surgery because the posterior bladder is no longer in a lower plane than the urethrovesical junction (Fig. 4).

It is pertinent to note that there is a small group of patients in whom stress urinary incontinence is the result of fibrous rigidity of urethra resulting from scarring of the anterior vaginal wall leading to inability of the internal

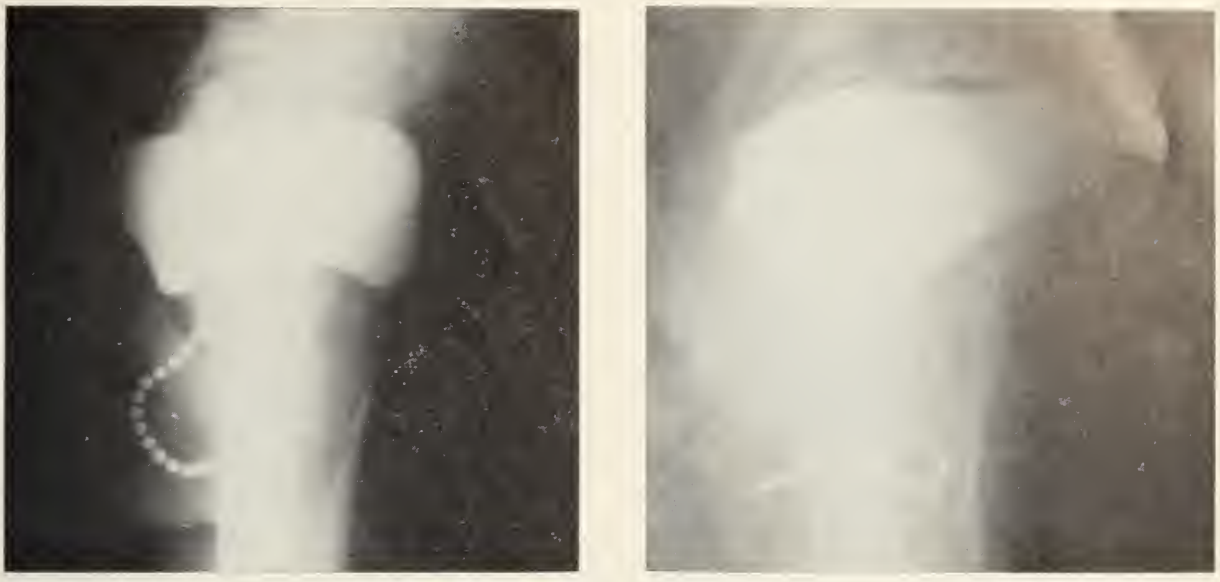


FIG. 2. Good PUV angle (left); PUV angle lost (right).

urethral meatus to close properly. In these patients, a normal PUV angle may be seen.[9] These cases will need further careful investigation and modification of treatment.

It is important to remember that anatomic appearances can be misleading in determining the relative position of the urethrovesical junction. For example, both a large cystocele and redundant vaginal mucosa appear *clinically* similar on pelvic examination. Radiographic methods help to define the urethrovesical angle more accurately. Therefore, we perform bead-chain studies in our routine evaluation of the incontinent female.

Selection of Treatment with Help of Bead-Chain Urethrocystograms

Aside from incidentally showing up calculi, foreign bodies, tumors,[10] urethrocystograms may also indicate medical rather than surgical treatment. The roentgen features of the neurogenic bladder are many and varied.[4,10] A very irregular, conical bladder with cellules and diverticulae (so-called "Christmas tree bladder"), or large, smooth, thin-walled, atonic bladder, or small, irregular, thick-walled, trabeculated, spastic bladder unable to hold the dye, may all be seen indicating neurogenic disease of the bladder. It is to be noted, however, that none of the above features is diagnostic and that they may also be seen in the patient without any neurogenic dysfunction of the bladder.

Selection of Operation with the Help of Bead-Chain Urethrocystograms

Various operative procedures have been described in past years for the correction of SUI in the female. Each procedure had a common principle, viz, elevation of the bladder neck (urethrovesical junction) to a level higher than the bladder base.[6] This was attempted by the vaginal or abdominal or combined approach. Before urethrocystography, a common rule was to effect a vaginal repair first and, if this failed, to operate from above. With accumulation of experience, physicians recognized that the initial procedure, irrespective of the approach used, has the



FIG. 3. Example of large cystocele with good PUV angle and no SUI.



Fig. 4. Cystocele prior to surgery — good PUV angle and no SUI (left); postoperative anterior repair showing excessive advance of bladder, loss of PUV angle, and development of SUI (right).

best chance of success.[6] Obviously, the importance of the appropriate preoperative decisions increases. Bailey,[11] in 1954, was the first to advocate the use of urethrocystograms in making this decision. In 1963, Green[12] modified Bailey's criteria employing the "type I and type II" classifications (Fig. 5), viz: type I, if there was purely increase or loss of PUV angle; and type II, if there was associated increase or loss of inclination to the vertical of upper urethral axis. As Hodgkinson[6] points out, Green's types do not include the patient whose bladder is in a very high position in relation to the symphysis pubis with normal urethral inclination (Fig. 6). He has simplified matters by recommending that no rigid criteria need be followed and that, if the urethrovesical junction is depressed to 4 cm or more below the lower border of the symphysis pubis, the vaginal approach should be considered, and if less than 4 cm, the abdominal approach is the best.[3] Hodgkinson based his opinion on experience gained from bead-chain urethrocystograms done both pre- and postoperatively. These make it evident that the elevation of the bladder neck relative to the symphysis pubis, which can be achieved by vaginal route, is limited.[6] Obviously, when the

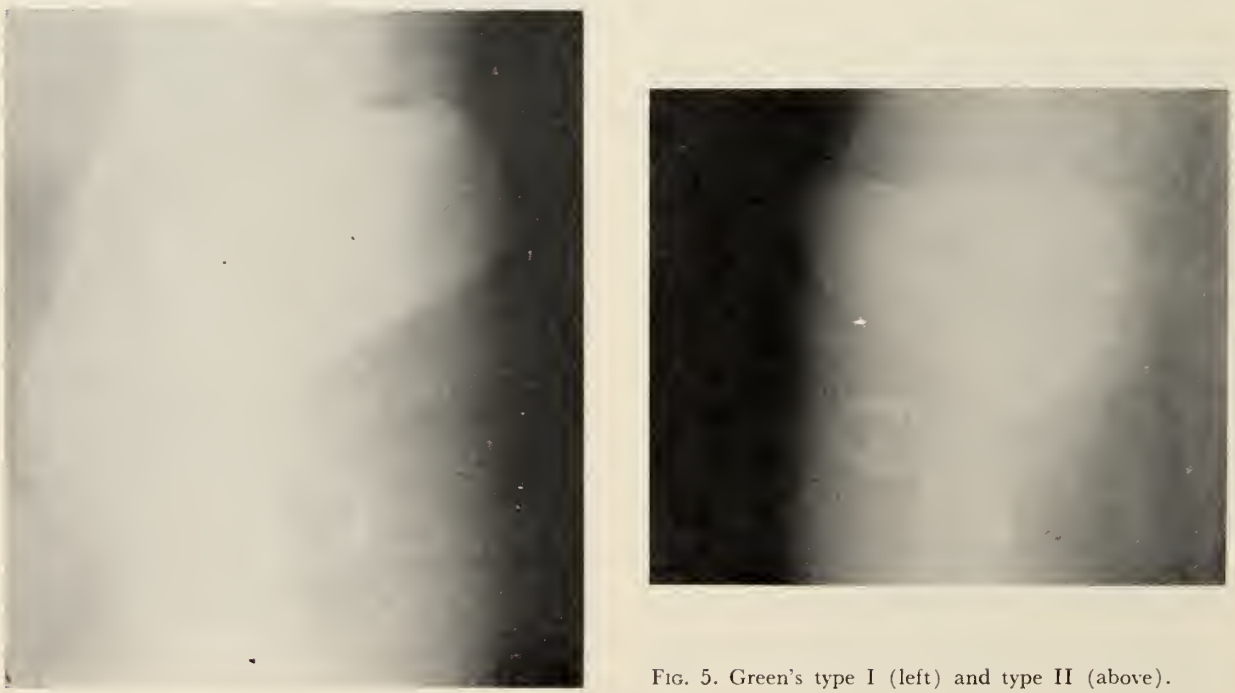


Fig. 5. Green's type I (left) and type II (above).

urethrovesical junction is already at a high level, satisfactory elevation to a higher level is difficult to obtain by the vaginal route. When the anterior vaginal wall is short and rigid, he recommends some "sling-type" operation.[6] We have followed these general principles in the management of our patients and have found the results very satisfactory. Further, when the urethrovesical junction is slightly lower than the symphysis pubis, without much bladder descensus, we have found that mere placement of Kelly's sutures to elevate the bladder neck results in continence because the position of the bladder base now is at a lower level than the urethrovesical junction. This is confirmed by postoperative bead-chain studies (Fig. 7).

Since the exact position of the urethrovesical junction and the relative position of the bladder and urethra can be accurately determined only by radiographic means and not by the anatomic configuration as seen by physical examination, bead-chain studies are indispensable to the gynecologist who must make the decision regarding the mode of surgical treatment in the individual patient.



Fig. 6. Example of high-positioned bladder in relation to symphysis pubis.

Summary

1. Urethrocystograms have contributed significantly to the better understanding of the topographic anatomy and functions of the bladder and urethra in the continent and incontinent female. Bead chains have improved the quality of these studies by better visualization of the spatial relationships of the bladder and urethra.

2. Many authorities in the field have established the bead-chain study as an essential part of the evaluation of any incontinent female.

3. Bead-chain studies are relatively simple and easy to perform. Uniformity of technic can be achieved provided studies are always carried out under the supervision of a physician.

4. Bead-chain studies aid not only in diagnosis but also in selecting the particular mode of





Fig. 7. Loss of PUV angle, slight bladder descensus, SUI present before surgery (left), and PUV angle restored and SUI relieved after placement of Kelly sutures around bladder neck (above).

treatment or operation suited to each individual case.

5. Bead-chain studies done *pre-* and *postoperatively* provide an objective graphic parameter by which results of various procedures done by the same gynecologist or different series done by different gynecologists can be compared without subjective bias.

Conclusion

Needless to say, bead-chain studies are indispensable in the armamentarium of the gynecologist in his continuing fight against SUI in the female.

Acknowledgment: The author is grateful to Melvern A. Ayers, M.D., Acting Chairman and Associate Professor, Department of Obstetrics and Gynecology, Medical College of Ohio at Toledo, for his expert guidance throughout the preparation of this article, and to Mrs. Carol Hardt for her assistance in the preparation of the manuscript.

Generic and Trade Names of Drugs

Benzalkonium chloride — Zephiran (Winthrop Laboratories)

Meglumine diatrizoate and sodium diatrizoate—Renografin (E. R. Squibb & Sons)

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E.N.T. Case of the Month

Andrew W. Miglets, Jr., M.D.*

This 37-year-old lady comes into your office with the ten-year history of bilateral, progressive hearing loss. She definitely noticed a decrease in her hearing during both of her pregnancies.

Her family history is significant in that her mother had worn hearing aids since her early 20s.

Her tympanic membranes (Fig. 1) appear normal. The incus can be seen through the very thin drum head.

What is her most likely diagnosis, and how may she be further evaluated?

(See p. 1108 of this issue for further information and discussion.)



Fig. 1. Tympanic membranes appear normal. Note the incus seen through very thin drum head.

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Submitted March 28, 1972.

Breast Cancer Survival
The Ohio State University Hospitals

John P. Minton, M.D.; Michael S. Sabback, M.D., and Kathern V. Oberle

SINCE 1962, The Ohio State University Hospitals have utilized a program of computerized cancer registration which in the past decade has provided us with a 99.98 percent follow-up on 904 female breast cancer patients. The registry records the extent of disease at the first University Hospital treatment, as well as primary and secondary forms of therapy and length of survival. This report summarizes our survival experience with breast cancer patients from January 1, 1962 to December 31, 1971.

The life table method[1,2] was applied to the survival data to generate the curves shown in the figure. The curve for all survivors represents the yearly survival of the total group of 904 patients. Survival curves for the 339 patients with localized disease, for the 275 patients with regional tumor involvement, and for the 233 patients with remote metastases are presented individually. Two other groups of 14 patients with carcinoma *in situ* and 53 patients with unspecified stage are included in the curve for all survivors. All survival data are corrected for normal mortality.[3]

The survival curve for those with localized disease reiterates the concept that *early detection is the major determinant in prolonging the survival of the breast cancer patient.*

A small percentage of patients with remote metastases at initial evaluation are noted to survive ten years. This survival in the face of widely disseminated disease implies the benefit of currently available therapeutic modalities, as well as the immunologic response of these patients to their neoplasm (host resistance).

Acknowledgment: The authors are grateful to Charles E. Little, Director of Data Processing, The Ohio State University, for his cooperation in providing these data.

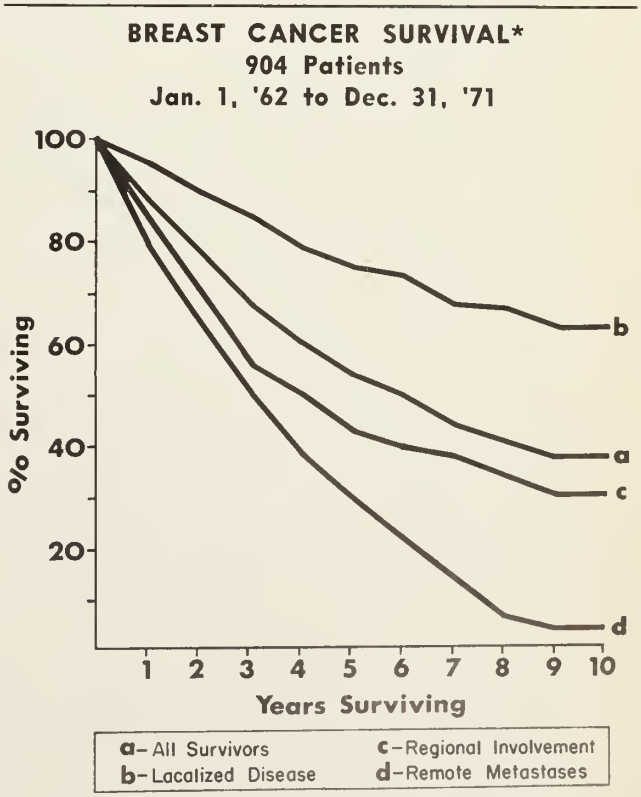
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• Mrs. Oberle, Columbus, is Assistant Director of Medical Records, The Ohio State University.



*The Ohio State University Hospital

Ocular Manifestations of Sphenoid Mucoceles

Case Report and Discussion

Dean Moore, M.D.; John M. Tew, Jr., M.D.; and Frank H. Mayfield, M.D.

MUCOCELES MAY OCCUR in any one of the paranasal sinuses. In the frontal sinus they produce headache, proptosis, and disturbances of ocular movement. Erosion of the anterior wall results in Pott's puffy tumor, subcutaneous abscess, while erosion of the posterior wall may produce epidural abscess, subdural empyema, meningitis, or brain abscess. Ethmoid sinus mucoceles encroach upon the medial wall of the orbit and the orbital fissure, producing proptosis and ocular palsies. The frontal and ethmoid sinuses are the two most common locations of mucocele. The least common location is in the maxillary sinus where, as Bloom[1] reports, the mucocele produces bulging of the turbinates with subsequent occlusion of the nasal passages, loosening of the teeth, erosion of the orbital floor and compression of the orbital fissure. However, ocular complications, proptosis, diplopia, and blindness may rarely occur as a result of maxillary mucoceles.

Mucocele of the sphenoid sinus, less frequent than those of the frontal and ethmoid sinuses, may present with a quite variable clinical picture. Retrobulbar neuritis, pituitary tumor, and ophthalmoplegic migraine are clinical conditions commonly confused with this disorder. A recent case of sphenoid sinus mucocele simulating each condition led to this presentation and a review of the subject.

Case Report

A 65-year-old white woman was admitted to the neurosurgical service of the Good Samaritan Hospital in Cincinnati, Ohio in October 1969 with the chief complaint of left frontotemporal headaches. The past history demonstrated that she was well until nine years prior to admission when she awoke one morning and discovered that she was blind in the left eye. For some time she had been troubled by intermittent headaches. Examination by her ophthalmologist disclosed a blind left eye and no other abnormalities. The blindness persisted and follow-up examinations showed progressive optic atrophy. A diagnosis of retrobulbar neuritis was made. Eight years later, she developed generalized weakness and had three or four syncopal episodes, which were attributed to an intestinal influenza syndrome. Three weeks prior to the present hospital admission, the patient developed intermittent left frontotemporal headaches with radiation of pain to the left ear. These headaches became constant and more severe after a few days.

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Submitted March 10, 1972.

One week prior to admission, she noticed ptosis of the left eye. There were no symptoms of upper respiratory infection or nasal congestion. The family history was positive for diabetes mellitus in both mother and father.

Neurologic examination demonstrated a blind left eye and marked pallor of the optic disc. There was incomplete left ptosis as well as paralysis of the extraocular muscles innervated by the third, fourth, and sixth cranial nerves. The pupils were equal; the right one reacted only to direct light. The left pupil had neither a direct nor a consensual reaction (Fig 1).

Normal laboratory data included complete blood count, urinalysis, serum electrolyte, and thyroid chemistries. Spinal puncture showed clear, colorless fluid under normal pressure. The spinal protein was 45 mg per 100 ml, and the cell count was normal. Brain scan, electroencephalogram, and glucose tolerance test were normal. Erythrocyte sedimentation rate was consistently elevated to 30 to 50 mm per hour, yet temporal artery biopsy was normal.

Skull radiographs showed erosion of the posterior clinoid processes, absence of the floor of the sella turcica, and opacification of the sphenoid sinus. Optic foramen views showed erosion and enlargement of the left optic foramen. A basal

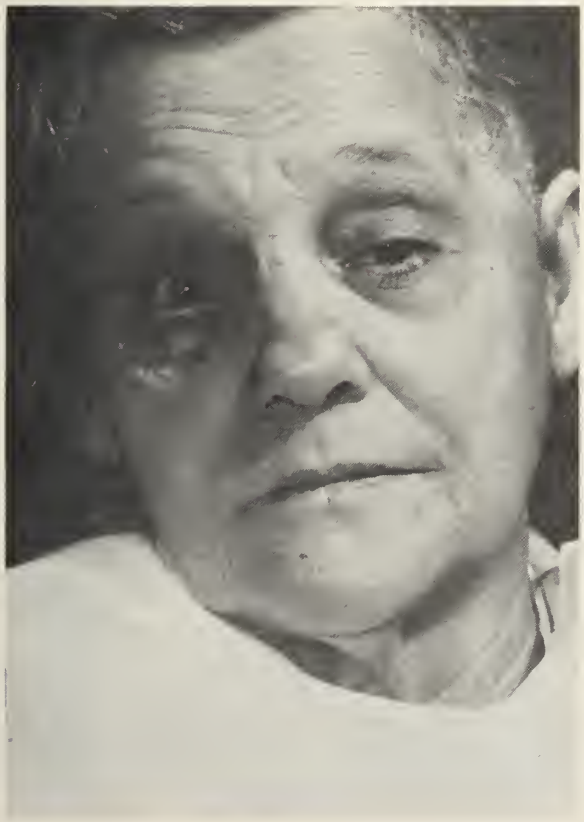


Fig. 1. Preoperative photograph of patient showing ptosis of left eyelid. Pupil was dilated and unresponsive to light. Ocular mobility was absent.



Fig. 2. Lateral skull radiograph shows (A) opacification of sphenoid sinus and absence of floor of sella turcica, (B) erosion of under surface of anterior clinoid process, and (C) destruction of posterior clinoid process.

view of the skull, submento vertex, showed marked ballooning of the sphenoid sinus and destruction of the interseptum of the sinus. A left carotid angiogram showed opening of the carotid siphon and lateral displacement of the cavernous segment of the carotid artery. A subtraction technic failed to disclose any abnormal vessels or tumor stain. A pneumoencephalogram showed moderate symmetrical dilatation of the lateral ventricles and ballooning of the diaphragma sellae into the chiasmatic cistern (Figs. 2-5).

A diagnosis of mucocele of the sphenoid sinus was made, and in conjunction with an otolaryngologist, the patient was explored through a sublabial —transnasal approach, and the preoperative diagnosis was confirmed. The operative findings consisted of a markedly enlarged sphenoid sinus filled with a cyst containing viscid, opaque fluid. The walls of the sinus were ballooned, and a septum was not present. The floor of the sella turcica was absent, and the dura overlying the pituitary gland was exposed.

Pantopaque was placed in the cavity, and operative x-ray films demonstrated the size of the cyst and its proximity to the left superior orbital fissure and optic canal. An opening from the sphenoid sinus into the left nasal cavity was established and the cyst wall exonerated (Figs. 6 and 7).

The patient's postoperative course was uncomplicated. Seven days after surgery, she was free of headache and showed full recovery of mobility in the left extraocular muscles (Fig. 8). However, the longstanding blindness in the left eye was un-

changed and has remained so to date. Two years after surgery, the patient remained asymptomatic except for permanent blindness in the left eye. Recent lateral and basal skull radiographs demonstrate aeration and contraction of the walls of the sphenoid sinus and reconstitution of the floor of the sella turcica (Fig. 9).

Discussion

Etiology: The etiology of mucoceles is unclear. They are defined as an accumulation or retention of mucoid material within a sinus as a result of continuous obstruction of the ostium of the sinus. The secretion is usually clear, thick, and tenacious, unless invasion by bacteria has occurred, creating a pyocele in which the color and consistency of the accumulated material varies with the infecting organism. Secondary erosion and distention of the



Fig. 3. Submento-vertex radiograph showing: (A) ballooning of wall of sphenoid sinus and (B) destruction of interseptum of sinus.



Fig. 4. Carotid angiogram. Anterior-posterior projection shows uncoiling of siphon and lateral displacement of cavernous portion of carotid artery.



Fig. 5. Pneumoencephalogram shows (A) posterior clinoid process, (B) pituitary stalk and optic nerve chiasm, (C) anterior third ventricle in normal position, and (D) ballooning of diaphragma sella.



Fig. 6. Anterior-posterior radiograph (operative) with sphenoid sinus filled with Pantopaque showing superior orbital fissure (A).

sinus walls occurs as the intraluminal pressure increases. Although retention of secretions from obstruction of the ostium is the most widely accepted cause, Dabney[2] demonstrated in a significant number of cases that the ostium is patent and seems adequate for normal drainage. Others[2] consider cystic dilatation of mucous glands of the epithelial lining of the sinus and cystic degeneration of polyps within the sinus as possible causes. Regardless of the cause, the cyst expands and compresses adjacent structures, causing alarming symptoms that prompt the patient to consult a physician.

Headache is the most common complaint and is usually localized to the frontal or retro-orbital areas. It is severe and may be intermittent or constant. Associated nausea and vomiting are uncommon. Spontaneous drainage with decompression accounts for remissions and exacerbations over a period of many years.

Ocular Symptoms: A recent review of the world literature by Nugent, Sprinkle, and Bloor[3] summarizes the important symptoms and findings. The most common ocular symptom is impaired visual acuity, which may suddenly progress to blindness as in the present case. It is usually unilateral but may be bilateral. Postoperative improvement in vision is the usual event, and restoration of sight to blind eyes has been reported. However, marked impairment of visual acuity or blindness of long duration is usually unchanged after surgical decompression.

Diplopia, second in frequency, is due most often to a third nerve paresis, yet sixth nerve or fourth nerve paresis may occur. Any combination of the three or ophthalmoplegia may exist.



Fig. 7. Lateral skull radiograph (operative) showing (A) optic foramen, (B) anterior clinoid process and dura of pituitary fossa, and (C) posterior clinoid process.



Fig. 8. Postoperative (five days) photograph of patient showing recovery of ptosis and function of 3rd, 4th, and 6th ocular nerves.

Exophthalmos is equally as common as diplopia. It is usually unilateral but was bilateral in four cases, and O'Shea[4] reported pulsating exophthalmos in one case.

Visual field deficits were the least common ocular finding, with central and peripheral deficits of about equal occurrence. Two patients blind in one eye had temporal hemianopsia in the other eye, and Nevins[5] reported one case of bitemporal hemianopsia.

Associated Symptoms: Less than one half of reported patients have a history of previous otolaryngologic disease such as sinusitis, nasal discharge, nasal mass, or polyp. The absence of such symptoms from the history probably contributes to the difficulty in diagnosis. As Nugent[3] pointed out, evaluation of pituitary function in four patients was normal. However, in Nevins' case[5] there was hypopituitarism manifested by decreased libido and easy fatigability and associated with low steroid levels in 24-hour urine samples. The postoperative 17-hydroxide and keto-steroids in our patient were normal.

Diagnosis: Although radiography establishes the diagnosis of sphenoid mucocele, a keen clinical suspicion is essential to prevent erroneous diagnosis of pituitary tumor, retrobulbar neuritis, ophthalmoplegic migraine, temporal arteritis and naso-



Fig. 9. Lateral skull radiograph showing (A) radiolucency of sphenoid sinus and reconstitution of sella floor, and (B) sella turcica in normal size and mineralization.

pharyngeal tumors. It is particularly important to differentiate this lesion from pituitary tumors since craniotomy may lead to fatal infection. Transnasal drainage is imperative. Radiographic findings consist of:

1. Opacification of the sphenoid sinus.
2. Ballooning and rarefaction of the bony wall of the sphenoid sinus.
3. Destruction of the interseptum of the sinus.
4. Erosion of the floor and walls of the sella turcica.
5. Lateral and upward displacement of the carotid arteries.

Tomography and carotid angiography are essential in the investigation of this lesion. Pneumoencephalography may also be helpful; however, suprasellar extension is usually absent.

Lundgren[6] proposed transnasal opacification of the sinus as a diagnostic test. Apparently helpful in several instances, we have used it to exclude sphenoid sinus mucocele.

Treatment: Transnasal drainage, imperative in approach, is curative if combined with exoneration of the cyst lining. However, longstanding blindness or ocular palsies may not recover fully. Early diagnosis and treatment is therefore essential.

Summary

The differential diagnosis of sphenoid mucoceles is legion. The ocular syndromes of retrobulbar neuritis, ophthalmoplegic migraine, and exophthalmos are three common modes of presentation of sphenoid sinus mucocele. We suggest that the evaluation of these ocular syndromes include strong clinical suspicion of sphenoid sinus mucocele and a thorough radiographic evaluation. This entity is simply treated through the nose and the results, in general, are excellent. An intracranial approach is to be avoided in all cases.

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CURE OF LUNG CANCER. — Three patients with lung cancer have been cured by incomplete removal of the cancer, which has for 20 years been the policy of this unit when complete removal is not possible. In each patient residual cancer remained on the wall of the left atrial chamber of the heart at the end of an operation for pneumonectomy.

Incomplete removal of cancer may, as a rare event, cure the patient. When residual cancer remained on any mediastinal structure other than the atrium cure has not been seen, though progress of the cancer seems to be retarded in some patients. — R. Abbey Smith, Ch.M., Coventry: *British Medical Journal,* 2:563-565, June 5, 1971.

Maternal Deaths Due to Air Embolism*

By the OSMA Committee on Maternal Health

FROM TIME TO TIME this column carries case reports involving the less common causes of maternal deaths in Ohio. The first article to present *three* case reports on "air embolism" in this series[1] appeared in 1959. However, during the past five years, the Committee has reviewed five cases of maternal death due to air embolism, three of which were associated with unusual sex acts during pregnancy. It would seem that this pathologic complex is seen more frequently in recent years.

The Committee herewith presents *eight* of the 13 unpublished case reports, from the Ohio Study, on maternal deaths due to *air embolus.* Although the incidence represents approximately 1 percent of the total cases in our files, members feel that physicians may wish to update their prenatal education information in order that future catastrophies may be prevented among pregnant females in Ohio.

Case No. 396

This was a 21-year-old, married, Negro, gravida II, para I, who died undelivered, six to eight weeks pregnant. The husband admitted that, in attempting to produce an abortion in his wife, he introduced a catheter into her vagina and blew air into it. The patient immediately complained of chest pains, gasped for breath, and died in respiratory distress. Administration of artificial respiration and oxygen were of no avail and she was pronounced dead on arrival at the hospital.

Cause of Death (Coroner's Autopsy): Venous air embolism due to mechanical (criminal) abortion; pregnancy circa two months; bilateral atelectasis and visceral congestion.

Comment

The Committee voted this case a preventable maternal death. Members wondered *how* the husband negotiated the anatomical position of the catheter and where he had learned about such a vicarious procedure.

Case No. 1381

A 23-year-old, married, Negro, primigravida died undelivered in the fourth month of pregnancy. No details are recorded in her past or present history. She was dead on arrival at the hospital, a rubber catheter extending from the vagina.

Cause of Death (Coroner's Autopsy): Attempted abortion by insertion of a rubber catheter into the uterus; air embolism; partial separation of the placenta; pregnancy, circa 4½ months gestation.

Comment

Committee members were hampered by a lack of information concerning the patient.

They voted this a preventable maternal death, based upon the coroner's report.

Case No. 1486

This patient was a 19-year-old, single, Negro, primigravida, who died undelivered in the third month of pregnancy. Nothing is known of her past. Her brother found her dead in her blood-spattered bathroom, from which she was removed to the nearest hospital.

Cause of Death (Coroner's Autopsy): Cardiac air

*A continuous statewide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in The Ohio State Medical Journal from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Submitted September 6, 1972.

embolism, secondary to attempted abortion; three-months pregnancy in situ; stellate lacerations of cervix radiating from the external os; pulmonary edema. (Heart opened under water.)

Comment

Again, with meager information on the patient. the Committee voted this case a preventable maternal death.

Members noted the pathologist's care in opening the heart under water; also, traumatic wounds to the cervix carried proof of the criminal act.

Case No. 1118

This patient was an 18-year-old, single, Negro, primigravida (?), who died undelivered with a three- to four-month gestation. Facts in the past history or present illness are not known; she was pronounced dead on arrival at the hospital.

Cause of Death (Coroner's Autopsy): Air embolism resulting from attempted abortion, circa three to four months (by persons or a person unknown, manner and method unknown); intrauterine pregnancy circa three to four months; blood clots in vagina; visceral congestion; peritoneal adhesions; small scars on legs.

Comment

Obviously, with so little information available, study and evaluation of facts in this case were impossible. The Committee voted this a preventable maternal death.

Case No. 1554

This was a 17-year-old, white, married primigravida, who died undelivered in her fourth month of gestation. Nothing was recorded in her past history; it was learned she had had *no* prenatal visits. While visiting her mother, she allegedly "took a cleansing douche" and became ill immediately. She lay down, became dyspnoeic, developed abdominal pain, and collapsed. Mouth-to-mouth resuscitation was ineffectual; she was pronounced dead on arrival at the hospital.

Cause of Death (Coroner's Autopsy): Venous air embolism, accidental during self-administration of a cleansing vaginal douche; pregnancy, intrauterine, circa 4½ months. (Heart opened under water.)

Comment

Members of the Committee were shocked with the course of events in this case, realizing the frequency with which human females utilize vaginal douches for "cleanliness." Discussion evolved about *how much* pressure was applied intravaginally by the patient; also, members wondered what type of solution was used, as well as the adequacy of instruction she had had in executing this delicate procedure known as "feminine hygiene." The Committee voted this a *preventable* maternal death (by a narrow margin). The pathologist's diagnosis was confirmed by opening the heart under water.

Case No. 568

This was a 29-year-old, married, white, gravida V, para IV, who died undelivered, 32 weeks pregnant. Details of the patient's past history were not recorded. Information indicates the patient had had prenatal care during the last pregnancy. The family physician reported that death of the patient occurred suddenly during an act of intercourse, subsequently leading to intrauterine fetal death; at the time he was summoned, fetal heart sounds were absent.

Cause of Death (Coroner's Autopsy): Pulmonary air embolism; partial separation of amnion from uterus; intrauterine pregnancy circa eight to nine months; acute and chronic cervicitis, atypical cervical epithelial hyperplasia.

Comment

The Committee voted this a nonpreventable maternal death, unavoidable castrophe. Members were somewhat puzzled concerning the source of entry of the "air" to produce the embolism, "separation of the amnion" (?). Furthermore, members wondered if *normal* coitus *was* an etiological factor in the maternal death.

Case No. 1500

A 19-year-old, single, white primigravida, died undelivered in her 36th week of gestation. She was pronounced dead on arrival at the hospital. Details in her history are meager; it is recorded that she had had an appendectomy but no previous pregnancies. Nor had she had prenatal care during this gestation.

Cause of Death (Coroner's Autopsy): Venous air embolism; pregnancy, third trimester (fetus 2275 gm); right hydronephrosis with local acute and chronic pyelonephritis, slight; separation of marginal sinus of placenta, on attachment near the cervix. (Bile and stomach contents, amphetamine present.)

Comment

This case was voted a nonpreventable maternal death, unavoidable catastrophe. From the data available, members of the Committee could not ascertain the precipitant mechanism for the entry of air into the circulation. Nor could the incidental discovery of amphetamine direct a clue toward either prescribed medication, or nefarious usage.

Case No. 1595

This patient was a 20-year-old, married, gravida II, para I, who died undelivered at 34 weeks gestation. Her past history was noncontributory, including a previous term pregnancy delivered without complications. Likewise, the present pregnancy had followed an uneventful course with only a 14-pound weight gain.

On the night of her death, the patient and her husband returned from a meeting, retired to bed, and engaged in sex play. Repeating a frequent practice, the husband blew air into her vagina with his mouth. Immediately she "fainted," was unconscious, and was pronounced dead on arrival at the hospital. The coroner viewed the remains, but a complete autopsy was not done; sincere remorse and profound depression in the husband, who was deeply in love with his wife, discouraged further investigation. The mortician declared "lots of air escaped from her carotid arteries when they

were cannulated; something I had never seen before."

Cause of Death (Coroner's Certificate): Cerebral air embolism; pregnancy, intrauterine, 7½ months.

Comment

The Committee studied available facts in this case with interest focused upon maternal, physiologic, and psychosexual features. Although proof is lacking, it may be assumed that the patient's prenatal counseling did not include "do's and taboos" of sex practices during pregnancy. After due deliberation, members voted this case a nonpreventable maternal death, unavoidable accident. Members silently commended the keen observation of the mortician, in absence of an autopsy.

Comment of Consultant

The following comment of a consultant, who is a specialist in obstetrics and gynecology, was furnished at the request of the Committee:

"Air embolism is a rare complication of pregnancy. As stated above, I am told the Ohio Maternal Mortality Study has compiled only 16 deaths from this bizarre etiology, among nearly 1600 cases. Nelson[2] found that nearly half of 199 *proven* cases of death from air embolism reported in the literature were secondary to attempted *criminal* abortion. Quite rarely, a suction therapeutic abortion may end in a fatal air embolism as an accidental catastrophe.[3]

"On the other hand, it is quite possible that some pregnant patients meet sudden death, and air embolism escapes diagnosis, either from the exclusion of an autopsy or from the pathologist neglecting to remember its possibility and not opening vital organs under water. Therefore, it is safe to assume that the incidence is greater than the literature records.

"The Committee has selected eight interesting cases for presentation. In the interest of brevity, I omit cases 1381, 1486, and 1118, criminal abortions, fully discussed by the Committee, with which I agree. Silver and Evans[4] cited 27 patients suffering air embolism after induced abortion; the symptoms, diagnosis, and management of the problem in one survivor were discussed.

"Case 396. Whether the intent of the husband was gratification or criminal termination of the pregnancy remains an enigma. Were charges pressed?

"Case 1554 represents a tragic misadventure! How many of us instruct our patients in the proper douching technic, especially the pregnant ones? Quite obviously this patient (as the Committee states) closed the introitus to create a 'flushing pressure.'

"In case 568, the problem will never be solved *if* all facts in the case are recorded (See case 1595, below). It would seem that ordinary coitus very rarely would terminate in such a catastrophe.

"Case 1500 presents an etiological puzzle *similar* to the one in case 568, except that a traumatic marginal separation of the (low) placenta could have allowed the entrance of air into the circulation. The source of trauma remains unknown. Was she 'fired-up on *speed*'?

"And in case 1595, although the fatal mechanism of the air embolism is clear, the whole process cannot but leave us in a state of deep pathos. I can only agree fully with the Committee's comment.

"Excluding criminal abortion as a contributing cause of fatal air embolism during pregnancy, other contributing causes must be remembered. Several are mentioned in these case reports: hygienic vaginal douches, the knee-chest position (exercise), powder insufflation as a treatment for vaginal infections,[2] and variations in sex play.

"Aronson and Nelson[5] reviewed the literature and reported *seven* deaths in pregnant women from air embolism, the result of air blown into the vagina during sex-play. They declare that the fact that such a variant of sexual activity exists at all may come as a surprise to most physicians, as might its potential lethal consequences! It is believed that variations in sexual technic representing departures from the usual methods, may stem from antiquated restrictions of coitus, at the time each period would be expected, and during the last month of pregnancy! Sexuality then, is expressed in mouth-genital contact and occasionally the partner may blow air forcefully into the vagina.

"*Prevention* is outlined by Herzig and Mojola.[6] Obstetricians can encourage uninhibited discussion (with pregnant patients) about acceptable (sex) practices, and can relieve anxiety while stressing the hazards of cunnilingus. Acceptable sex play for nonpregnant women may be fatal to the pregnant woman.

"The Committee is to be congratulated upon its presentation of these eight cases from the Ohio Study. This consultant is pleased to participate in its educational program."

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Discussion of E.N.T. Case of the Month

(continued from p. 1098)

During further testing, the patient was unable to hear a softly spoken voice presented approximately 2 feet from either ear canal, indicating a fairly severe degree of hearing loss.

The *type of loss* was determined with use of the 512 and 1042 Hz tuning forks. When the tuning fork was held to her forehead, she heard it with equal intensity in both ears (the Weber test did not lateralize). When asked to compare the loudness of the tuning fork when the tines were held opposite her ear canal, as opposed to when the base of the fork was applied to the mastoid area, she heard the tuning fork louder when it was held to the mastoid (negative Rinne test). This was present in both ears, indicating a bilateral conductive or mechanical-type hearing loss.

The loss was confirmed with an audiogram (Fig. 2). The right ear only is shown for clarity. Note that the level of bone conduction (arrows) is near the 0 db level, indicating good function of the inner ear. However, when the sound was introduced into the ear canal (air conduction represented by dots) she exhibits a 50 db loss. This discrepency between the air and bone conduction confirms a *mechanical or conductive type of hearing loss.*

Her diagnosis was bilateral otosclerosis. This

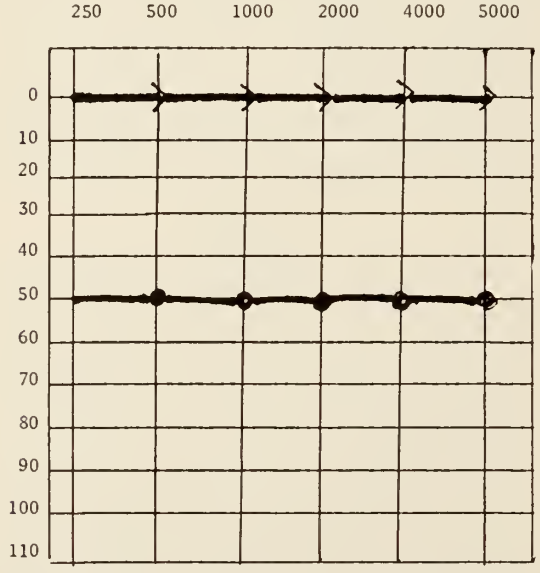


Fig. 2. Audiometric evaluation showing bone conduction (arrows) is normal, while air conduction (dots) is down to 50 db level.



Fig. 3. A wide variation of prostheses are available to connect incus with oval window of inner ear. Arrow points to a surgically removed stapes bone. For comparison, a 1946 dime (now worth 6½¢) is shown.

is a disease entity in which an abnormal vascular bone develops in the otic capsule near the attachment of the stapes bone. When impingement upon the stapes occurs, it's ability to transmit the vibrations of sound is impaired, and a conductive hearing loss results. Patients with otosclerosis will usually have normal appearing tympanic membranes and a progressive conductive hearing loss that may begin during early adulthood.

Hearing loss due to otosclerosis may be corrected surgically. Usually the stapes bone is removed entirely and replaced with a prosthesis which connects the incus to the inner ear. A great variety of prostheses is available to meet the minor variations that occur within the ear, a few are pictured here (Fig. 3). Patients with otosclerosis may also benefit from the use of a hearing aid.





Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Upper respiratory congestion and hypersecretion associated with the common cold, acute and chronic sinusitis, vasomotor rhinitis; allergic rhinitis (hay fever, "rose fever," etc.).

Contraindications: Hypersensitivity to any component, concurrent MAO inhibitor therapy; severe hypertension, bronchial asthma; coronary artery disease; stenosing peptic ulcer; pyloroduodenal or bladder neck obstruction. Children under 6.

Warnings: Advise vehicle or machine operators of possible drowsiness. Warn patients of possible additive effects with alcohol and other CNS depressants.

Usage in Pregnancy: In pregnancy, nursing mothers and women who might bear children, weigh potential benefits against hazards. Inhibition of lactation may occur.

Effect on PBI Determination and I^{131} Uptake: Isopropamide iodide may alter PBI test results and will suppress I^{131} uptake. Substitute thyroid tests unaffected by exogenous iodides.

Precautions: Use cautiously in persons with cardiovascular disease, glaucoma, prostatic hypertrophy, hyperthyroidism.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; or insomnia. Also, nausea, vomiting, epigastric distress, diarrhea, rash, dizziness, weakness, chest tightness, angina pain, abdominal pain, irritability, palpitation, headache, incoordination, tremor, dysuria, difficulty in urination, thrombocytopenia, leukopenia, convulsions, hypertension, hypotension, anorexia, constipation, visual disturbances, iodine toxicity (acne, parotitis).

Supplied: Bottles of 50 capsules.

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ORNADE® SPANSULE®

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Each capsule contains 8 mg. of Teldrin®(brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

UNCOMMON RELIEF FOR COLD SYMPTOMS

If you've seen one, have you really seen them all?

The following patient profiles represent typical clinical situations, but do not necessarily represent actual cases.

Age 22, previously normal menses with occasional menorrhagia. Now on a sequential O.C. for four months. Complains of heavy flow, occasional intracyclic bleeding, edema, tender swollen breasts.

Indicates estrogen excess.

1st choice: Switch to a combination 50-mcg.-estrogen O.C. (such as **Demulen**®).

Age 19, small breasts, minor hirsutism, oily hair and skin. History of metrorrhagia, skipped or scanty menses. New user.

Indicates androgenic excess or estrogen deficiency (fertility is suspect).

1st choice: An estrogen-dominant O.C. (such as **Enovid-E**®).

Age 25, average frame, poor complexion. No problem with menses, normal para 1. On a low-estrogen/high-progestogen O.C. for two years. Now complains of scanty flow, decreased libido, depression.

Indicates probable buildup of progestogen-related side effects.

1st choice: Switch to a center-spectrum O.C. with more estrogen, less progestational activity (such as **Ovulen**®).

Age 21, short, mammose, with normal menses, some acne. Was put on prenuptial regimen of 50-mcg.-estrogen/moderate-progestogen O.C. for two months. Now has increased acne.

Indicates metabolic production of androgen or relative estrogen deficiency.

1st choice: Switch to a 100-mcg.-estrogen combination (such as **Enovid-E**® or a sequential).



Unmasked, physiologically and anatomically, they're not all the same. A basic difference lies in their hormone profiles. One may secrete too much estrogen, another not enough...or perhaps too much androgen; the vast majority would fit somewhere into the broad center spectrum.

Although the profiles described below may not be completely predictive, in optimal O.C. selection, the estrogen-progestogen activity ratio should be carefully matched to the patient profile. Searle offers you O.C.s in a range not only suitable for your patients in the balanced center spectrum, but also adaptable to the patient with another type of hormone profile.

Oral contraceptives are complex medications. Among the commonly reported adverse reactions are: intracycle bleeding, fluid retention, tender or swollen breasts, exacerbation of acne condition, changes in libido, amenorrhea while on medication and upon discontinuance, nausea, leg cramps, headaches, weight gain. Therefore, after reference to the prescribing information, oral contraceptives should be prescribed with care.

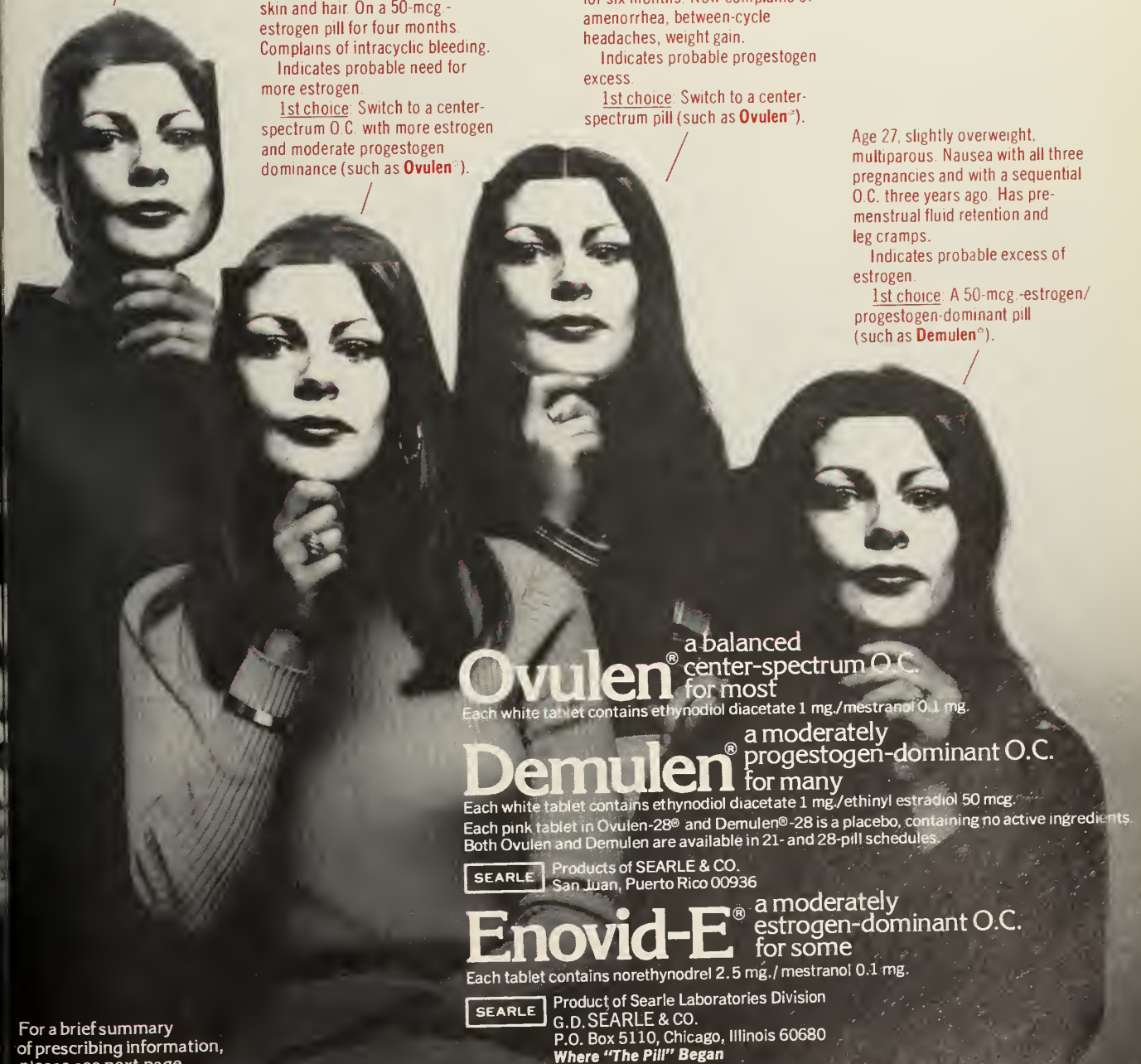
*Note: In some patients any level of exogenous estrogen or progestogen may produce symptoms of excess hormone activity.

Age 25, tall, slender, athletic, with flat chest. On a progestogen-dominant 50-mcg.-estrogen O.C. Has recurrent trichomoniasis and Monilia.
Indicates estrogen deficiency and excess of progestogen in current O.C.
1st choice: Switch to a combination pill with 100 mcg. estrogen and less progestational activity (such as **Enovid-E*** or **Ovulen*** or a sequential).

Age 23, "Miss America" figure, previously normal menses, healthy skin and hair. On a 50-mcg.-estrogen pill for four months. Complains of intracyclic bleeding.
Indicates probable need for more estrogen.
1st choice: Switch to a center-spectrum O.C. with more estrogen and moderate progestogen dominance (such as **Ovulen***).

Age 21, college senior, average build. On highly progestogen-dominant/low-dose-estrogen O.C. for six months. Now complains of amenorrhea, between-cycle headaches, weight gain.
Indicates probable progestogen excess.
1st choice: Switch to a center-spectrum pill (such as **Ovulen***).

Age 27, slightly overweight, multiparous. Nausea with all three pregnancies and with a sequential O.C. three years ago. Has premenstrual fluid retention and leg cramps.
Indicates probable excess of estrogen.
1st choice: A 50-mcg.-estrogen/progestogen-dominant pill (such as **Demulen***).



Ovulen® a balanced center-spectrum O.C. for most

Each white tablet contains ethynodiol diacetate 1 mg./mestranol 0.1 mg.

Demulen® a moderately progestogen-dominant O.C. for many

Each white tablet contains ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
Each pink tablet in Ovulen-28® and Demulen®-28 is a placebo, containing no active ingredients.
Both Ovulen and Demulen are available in 21- and 28-pill schedules.

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Enovid-E® a moderately estrogen-dominant O.C. for some

Each tablet contains norethynodrel 2.5 mg./mestranol 0.1 mg.

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Each pink tablet in Ovulen-28* and Demulen*-28 is a placebo, containing no active ingredients.

Actions – Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note – Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Ovulen and Demulen are indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations pre-existing uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Actions – Enovid-E acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Enovid-E depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Indication – Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

Enovid-E®

brand of norethynodrel with mestranol

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Where "The Pill" Began

272R

Hypersensitivity Pneumonitis

II. A Discussion of Bird Breeder's Lung

William F. Hughes, M.D.

THIS TYPE OF ALLERGIC lung disease is second in frequency to Farmer's Lung in this country. It was originally described by Reed, et al[1] in 1965. They reported three patients who had many episodes of acute interstitial pneumonitis after exposure to pigeons which they bred as a hobby. The following year a somewhat similar group of cases, in which the patients were exposed to parakeet antigens, was reported from Great Britain by Hargreave.[2]

The individual who gets the disease from parakeet exposure presents with an entirely different clinical picture from the rest of the hypersensitivity lung diseases. They are exposed to small amounts of avian antigens over a long period of time, which results in a very insidious illness. They usually experience a series of very minor respiratory problems which eventually results in a severe degree of diffuse pulmonary fibrosis. Nearly always, this stage of the disease is present when the diagnosis is made.

The antigens involved are the small amounts of the bird serum proteins which appear in the feces. An additional source of these proteins in the litter of the cage is from the single drop of blood that is shed each time a new feather erupts from the skin. Both the albumin and globulin fractions of the pigeon serum are antigenic, but the latter appears to be the stronger antigen.[3]

The raising and racing of pigeons is a worldwide hobby, involving thousands of individuals. It is well organized and there are many clubs in the United States. For example, Ohio has many active clubs with well over 1,000 members. This sport revolves around the speed with which a pigeon will return to his home loft after being released a specific distance away. The crux of the race is often the end when the pigeon breeder has to hand catch each bird and clock it in. In order to be able to do this efficiently, an individual will spend 30 minutes to two hours with the birds every day. Usually, the loft is cleaned once a week and this job is often extremely dusty. The classical onset of the illness then occurs four to six hours after cleaning the loft. Symptoms include low-grade fever, malaise, dyspnea, and an irritative cough. The first espisodes may be extremely mild with progressive severity on subsequent exposures. Finally, even the briefest exposure in the loft may bring on symptoms a few hours later. Patchy, usually basilar, pneumonitis can occur, just as in Farmer's Lung. In the acute episode, the predominant pulmonary function abnormality is reduction of diffusion capacity. The diagnosis can usually be substantiated by demonstrating antibodies to pigeon serum proteins in the patient's serum. Although about one third of asymptomatic pigeon breeders have pre-

The Author

• **Dr. Hughes, Columbus, is Assistant Clinical Professor of Medicine, Pulmonary-Allergy Division, The Ohio State University College of Medicine, and a member of the Attending Staffs of The Ohio State University Hospitals, and Riverside Methodist Hospital.**

Submitted March 6, 1972.

cipitins in their serum, the titer is distinctly higher in those with disease. The actual number assigned as the titer varies, depending on the methods. In our laboratory, precipitin titers above 32, as determined by gel diffusion, or over 100,000 by hemagglutionation strongly favor active disease. The value of a direct skin test with pigeon serum (heat inactivated at 56 F for 30 minutes)* in the diagnosis is controversial. In the early description of the disease from England, a positive immediate wheal and flare reaction was described, followed four to six hours by a diffuse, painless swelling. This later reaction is a classic Arthus phenomenon. The latest group of pneumonitis cases reported in children did not have a significant immediate skin test but did have the Arthus reaction.[4]

No specific treatment is usually needed. If the alveolitis does not clear dramatically in 10 to 14 days by avoiding further exposure, it will respond to moderate steroid administration for a short time. There is a high risk of developing severe, crippling lung disease after repeated episodes of this kind of pneumonitis. Prevention of these attacks is very important and can be accomplished by strict avoidance of exposure, but this is often very difficult to achieve. The attachment of these individuals for their birds is tremendous, and almost invariably they will resist giving up the hobby. In these circumstances, reduced exposures and the wearing of an effective mask may be of some help. Several affected individuals are able to continue to participate in the sport by wearing the mask on every visit to the loft and by arranging for someone else to do the cleaning.

The mechanism of production of this disease, as well as the other types of hypersensitivity pneumonitis, has been thought to be an allergic reaction of the Type III variety. This is according to Gell and Coombs' classification of the spectrum of allergic diseases.[5]

The patient, usually nonallergic in the usual sense, develops large amounts of IgG antibody in response to repeated inhalation of these protein substances. At some time in the course of exposure, when the ratio of inhaled antigens is in excess of the circulating antibody, soluble antigen-antibody complexes form and the complement cascade is activated. In this process, leukocytes are attracted and aggregated and the inflammation is most intense along the alveolar septa.

It is beginning to appear that these diseases may not be due exclusively to this circulating IgG antibody that can be detected so easily by gel diffusion, but this simple technic is still valuable in helping to establish a diagnosis. The histology of the lung lesions gave the first clue that classic delayed hypersensitivity might play a role. Recent studies [6,7] have reproduced these diseases in rats and rabbits by methods which institute cell-mediated hypersensitivity primarily. This remains an active field for research and may well be a situation where several immunologic mechanisms are involved.

*Destroys psittacosis virus.

Summary

The second commonest allergic alveolitis in the United States is probably Bird Breeder's Lung. The syndrome of malaise, cough, and dyspnea has its onset four to six hours after exposure to avian proteins. Basilar pneumonitis often occurs, and repeated episodes lead to severe chronic pulmonary fibrosis. Thus, recognition and prevention of these recurrent attacks are extremely important. The possible mechanisms for the production of these lesions have been reviewed.

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Professional Activities



Proceedings of The Council

Meeting of September 29, 30 and October 1

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Friday, Saturday and Sunday, September 29, 30 and October 1, 1972, at Sawmill Creek Lodge, Huron, Ohio.

Those present Friday evening were: All members of the Council (except Dr. David Fishman, Cleveland; Dr. Maurice F. Lieber, Canton; Dr. William M. Wells, Newark, and Dr. James C. McLarnan, Mt. Vernon); Dr. John W. Cashman, Columbus, Ohio Director of Health; Dr. James E. Pohlman, Columbus, legal counsel; Messrs. Hart F. Page, Charles W. Edgar, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, David L. Rader, Mrs. Katherine E. Wisse, Mr. R. Gordon Moore, and Mrs. Gail Dodson.

Those present Saturday were: All members of the Council; Dr. John H. Budd, Cleveland, a member of the AMA Board of Trustees; Mr. William J. Lee, Columbus, Administrator of the Ohio State Medical Board; Dr. James F. Schieve, Cincinnati, Associate Dean of the University of Cincinnati College of Medicine; Mr. Pohlman, and all members of the OSMA Staff.

Those present Sunday were: All who were present Saturday, and Dr. Richard L. Meiling, Columbus, Chairman of the Ohio Delegation to the AMA; Dr. Robert J. Atwell, Columbus, Acting Dean, Ohio State University College of Medicine, and Dr. Harry A. Killian, President of the Ohio Academy of Family Physicians.

Minutes Approved

Minutes of the meeting of July 28-30, 1972 were approved.

Councilor Reports

The Councilors reported on activities in their respective districts.

Dr. Cashman Addresses Council

Dr. John W. Cashman, Ohio Director of Health, addressed the opening session of the Council. He discussed budget problems, hospital licensing, the kidney program, the transfer of environmental health jurisdictions to the new Environmental Protection Authority, the combining of the Toledo and Columbus areas for Regional Medical Planning, the Cleveland hospital problem and the Ohio Department of Health's new role in the Title XIX Program.

Dr. Robechek Elected

The President announced that Dr. Robechek has been chosen President-Elect of the Ohio Chapter of the American College of Surgeons.

OSMA Speaker's Training Seminar

Dr. Schultz and Mr. Edgar reviewed the OSMA Speaker's Training Seminar for members of the Woman's Auxiliary, held September 21-22, 1972. Council, by official action, expressed its thanks to Messrs. Robert Lang, Executive Secretary, and Alex Lagusch, Assistant Executive Secretary of the Academy of Medicine of Cleveland, and to Mr. Edgar.

(Continued on Next Page)

Membership and Fiscal Matters

Mrs. Wisse presented membership statistics, as follows: Total membership as of September 29—10,221, as compared to 10,314 at year's end, 1971.

Mrs. Wisse also reported on a special campaign, in cooperation with David B. Weihaupt, Director of Membership and Planning of the American Medical Association, to obtain new members for county medical societies, OSMA and the American Medical Association.

A progress report on computer membership systems was presented by Mrs. Wisse.

Legal Counsel was instructed to draft, in cooperation with the Committee on Membership and Planning, changes in OSMA Bylaws to provide active membership for interns and residents. It was directed that the draft be returned to the Council, in order that it may be considered for introduction in the OSMA House of Delegates.

American Medical Association

Dr. Meiling and Mr. Gillen reported on developments in preparation for the Clinical Session of the American Medical Association, to be held in Cincinnati, November 26-29.

OSMA Annual Meeting

Mrs. Dodson presented a progress report on the Ohio State Medical Association Annual Meeting for 1973.

Mr. Campbell discussed plans for the scientific and technical exhibits.

Revised Model Constitution and Bylaws

Mr. Page presented a progress report on the adoption of the revised "model" county Constitution and Bylaws. The Council instructed Mr. Page and legal counsel to check Codes of Regulations of the larger incorporated county societies and the Constitution and Bylaws of the unincorporated county societies, to see if they are in conformity with the revised OSMA Bylaws and that a communication be directed to those counties who have not complied.

Geauga County

Revision of the Constitution and Bylaws of the Geauga County Medical Society **was approved** by the council.

Committee Reports

Committee on Public Relations

Minutes of a meeting of the Committee on Public Relations, held July 26, 1972, were presented by Mr. Edgar and **approved in principle.**

Subcommittee on Control of Prescriptions (Committee on Mental Health)

Minutes of the Subcommittee were considered in conjunction with minutes of the Committee on Mental Health.

Committee on Mental Health

Minutes of a meeting of the Committee on Mental Health, held August 20, 1972, were presented by Mr. Clinger. In considering the minutes, the Council **approved** a study of a "triplicate prescription system" or a similar control system conducted jointly by the Ohio State Medical Board, the Ohio Board of Pharmacy, the Ohio State Pharmaceutical Association and the Ohio Osteopathic Association of Physicians and Surgeons.

Also **approved** was a committee recommendation that OSMA endorse, in principle, the Ohio Hospital Association proposal to conduct multidisciplinary training programs on drug abuse for both acute care personnel and administrative personnel in Ohio hospitals.

The Council noted the committee's recommendation that OSMA establish liaison with Mr. Kenneth DeShetler, Director of the Ohio Department of Insurance concerning mental health benefits in hospitalization insurance. The Council directed that such liaison be within the jurisdiction of the Committee on Insurance and that exploration of the matter of mental health benefits in hospitalization insurance continue to be in the province of the Committee on Insurance.

Joint Committee on School Bus Driver Examinations

Minutes of a meeting of the Joint Committee on School Bus Driver Examinations, held August 8, 1972, were presented by Mr. Clinger, and were accepted as a progress report.

Committee on Membership and Planning

The minutes of a meeting of the Committee on Membership and Planning, held August 9, 1972, were presented by Dr. Wells and Mr. Gillen. The main thrust of the meeting was a conference with representatives of the specialty societies, concerning an anticipated OSMA program providing services for these societies. The minutes were accepted as presented.

Agreement with Specialty Societies

A proposed contract agreement for use in making arrangements to provide services for specialty societies was presented by Mr. Campbell and

was amended and approved by the Council. The Council authorized Dr. Schultz, Dr. Wells and Mr. Campbell to continue discussions with the present groups and other appropriate organizations and to make decisions on priorities of enrollment.

Committee on Scientific Work

Minutes of a meeting of the Committee on Scientific Work, held August 16, 1972, were presented by Mrs. Dodson. Council **approved** the theme of the Annual Meeting for 1973, and amended the suggestions of the committee with regard to the first day's program, including arrangements for the House of Delegates, due to the unavailability of Dr. William H. and Virginia E. Masters as speakers.

The Sunday program now, as amended, is as follows:

3:00-7:00 P.M.
Registration for OSMA House of Delegates
Terrestrial Promenade
Second Floor
Sheraton-Columbus Hotel

4:00 P.M.
Councilor District Caucuses
Sheraton-Columbus Hotel

5:30 P.M.
Buffet Dinner for Delegates, Alternates
OSMA Council and Official Guests
Mars and Venus Rooms, Second Floor
Sheraton-Columbus Hotel

7:00 P.M.
OSMA House of Delegates, First Business Session
Jupiter and Saturn Rooms, Second Floor
Sheraton-Columbus Hotel

Four continuing medical education sessions for Tuesday morning and continued on Wednesday morning, with a fee of $10 per person, **were approved.**

The Council **approved** the committee's suggestion that the annual social function be held at Scioto Downs and that James L. Henry, M.D., serve as chairman of this function.

A loyalty commendation for long-time technical exhibitors **was approved.**

The Council **approved** a suggestion that the OSMA not conduct audio taping of selected Annual Meeting Sessions, but directed that Audio-Digest be asked to audio tape the four continuing medical education courses at the 1973 Annual Meeting.

The Council **disapproved** a committee suggestion that resolutions be assigned to Reference Committees prior to the Annual Meeting and that such information be circulated in advance. It was pointed out that assignment schedules, due to acceptance of late resolutions by the House, must be somewhat tentative in nature. With this understanding, there was no objection to assignment schedules being available at the time of delegate registration for the first session of the House.

Since the Sunday program has been discontinued, a suggestion that Beverley T. Mead be contacted as an alternate for Masters and Johnson was dropped from consideration.

A suggestion, with regard to obtaining scientific exhibits was amended to suggest that the chief officer of the medical staff of smaller hospitals be contacted with regard to availability of such exhibits.

The report of the committee as a whole, as amended, **was approved.**

Commission on Medical Education

The minutes of a meeting of the Commission on Medical Education, held August 30, 1972, were presented by Mr. Edgar. With regard to establishing a position for the officers of the OSMA in discussing physician assistant proposals with the Ohio State Medical Board, the Council expressed itself as being in general support of the principles adopted by the House of Delegates of the American Medical Association in connection with its acceptance of a report from the Council on Medical Education.

Council then discussed the Ohio Board of Regents report on medical education with Richard L. Meiling, M.D., Vice President of Medical Affairs, The Ohio State University, Robert Atwell, M.D., Acting Dean of the College of Medicine of The Ohio State University and James F. Schieve, M.D., Associate Dean of the University of Cincinnati College of Medicine. At the conclusion of the discussion, the Council voted to take no specific stand with regard to the report at this time, authorized Association participation in any committee studies with regard to the report and decided to communicate with the Chancellor of the Board of Regents, indicating the desire of the Association to become involved in any studies connected with the report.

The report **was accepted,** as amended.

Committee on Emergency and Disaster Medical Care

Minutes of a meeting of the Committee on Emergency and Disaster Medical Care, held September 10, 1972, were presented by Mr. Rader. With regard to the suggestion of the committee that alternates to each committeeman be appoint-

ed, Council directed that consideration be deferred until the committee is fully organized and active.

Action of the committee, on page 4 of the minutes, was amended to read "The Committee requests that legal counsel of OSMA review liability ramifications of categorization." The Council **approved** the report, as amended.

Committee on Insurance

The minutes of a meeting of the Committee on Insurance, held September 20, 1972, were presented by Mr. Campbell. The Council amended a suggestion of the committee with regard to OSMA Resolution 36-72 (Average Length of Stay) to read as follows: that "the following statement be accepted for distribution to Blue Cross of Northwest Ohio and other third parties when indicated: 'Peer review and or utilization committees must exist and operate effectively to insure appropriate medical advice and control. The peer review or utilization committee must be the final authority in the determination of medical necessity'."

The Council **approved** the committee's recommendation that the OSMA should not, at this time, survey its membership on the subject of professional liability.

A suggestion of the committee was amended to direct that the Association contact the deans of the four medical schools in Ohio and their respective curriculum committees regarding the importance of courses on medical jurisprudence with emphasis on malpractice prevention.

The Council **approved** the suggestion that the OSMAgram, four times a year, bring attention to the fact that the OSMA is, and has been, available to assist and advise members on professional liability matters.

The Council **accepted** the committee's recommendation that the Association develop a simple, concise medical legal guide on professional liability for OSMA members and requested that the draft be returned to the Council for approval.

The Council **accepted** the committee's recommendation that the OSMA not pursue, at this time, sponsoring of a mass merchandising program of automobile insurance for OSMA members.

The Council **approved** the committee's recommendation with regard to Am. Resolution No. 56-72 (Relative Value Fee Schedule) and amended it to read as follows: "The intent of Resolution No. 56-72 be implemented by accepting the following statement: 'The OSMA Council and Committee on Insurance have evaluated the concept of Relative Value Fee Schedules and totally reject the theory and application of Relative Value Fee Schedules in determining payment for professional medical services.

" 'Individual physicians are encouraged to establish their fees for individual services in accordance with their own estimates of the value of the service, the time spent, materials used and the economics of their own particular practices. The **Relative Value Studies** is not a schedule of fees, nor should it be misconstrued as such. It may, however, be used as a "guide" by physicians to assist them in establishing fees.' "

The committee reported to the Council that a progress report on Resolutions 9-71 (Clarification of Third Party Responsibility) and 12-71 (Professional Liability Insurance) was accepted by the Committee on Insurance "for information."

OSMA Resolutions 9-72 (Proposed Solution to Current Malpractice Problem) and 10-72 (Attorney's Contingency Fees in Relation to Current Malpractice Problems) were discussed by the committee and held over for further discussion at a future meeting.

The committee reported to the Council that it had also deliberated on Resolution 49-72 (H.R. 1) and docketed the matter for further discussion.

The report as a whole **was approved** as amended.

OSMA Major Medical Coverage Extension to Employees of OSMA Members

The Council **approved** a recommendation to give employees of OSMA members the opportunity to apply for coverage under the OSMA-sponsored Major Medical Plan.

Committee on Government Medical Care Programs

Minutes of the September 27 meeting of the Committee on Government Medical Care Programs were presented by Mr. Gillen.

The committee reported discussion on Resolution 12-72 (Funding for Comprehensive Health Planning).

With regard to Resolution 13-72 (Medicare Part B), the Council **approved** the committee's recommendation that the Association reaffirm its previous position on direct billing. The Council directed that a communication be addressed to the new Congress, pointing out the hardships to the elderly being wrought by the inadequacies and drastic reductions in Medicare Part B.

The committee reported deliberations on Resolution 23-72 (Invoice for Health Care Under Medical Assistance Programs); Resolution 34-72 (Health Care — A Negotiable Service); Resolution 44-72 (Regional Medical Programs), and Resolution 49-72 (H.R. 1). With regard to Resolution 49-72, Council instructed the Committee on Government Medical Care Programs to keep

informed of developments concerning H.R. 1 in Congress and to bring testimony to the appropriate Congressman at the proper time.

With regard to Resolution 56-72 (Relative Value Fee Schedule), the Council expressed its position as that policy adopted in connection with the minutes of the Committee on Insurance, September 20, 1972, and amended by the Council on September 30, 1972.

The report as a whole **was approved** as amended.

Joint Advisory Committee on Sports Medicine

The minutes of the meeting of the Joint Advisory Committee on Sports Medicine, held September 24, 1972, were presented by Mr. Clinger.

The first paragraph of page 2 of the report was amended.

The Council **approved** the preparation, printing and distribution of a pamphlet on heat strokes, but asked to see the final draft.

Suggestion number 6 of the committee, "that the OSMA strongly request team physicians to be on the scene during tests of conditioning — both pre-season and after practice sessions have begun," was deleted and the report was approved as amended.

Committee on Maternal Health

A revision of the "Guiding Principles for Obstetric Care," prepared and presented by the Committee on Maternal Health of the OSMA, **was approved.**

Committee on Auditing and Appropriations

The minutes of a meeting of the Committee on Auditing and Appropriations, held September 30, were presented by Mrs. Wisse. The report **was approved** as presented.

Council Committee on Fee Review

The minutes of a September 30 meeting of the Council Committee on Fee Review were presented by Dr. Bates.

The committee presented the following case with its recommendations:

"In this particular case, and with the information provided for review, the committee was of

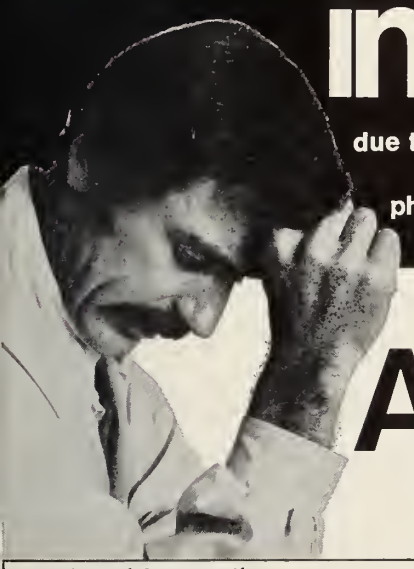
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References: 1. Montesano, P., and Evangollete, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titoff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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the opinion that this case involves overcharging and overutilization. It is the committee's recommendation that in this particular case six visits to the physician's office would be the maximum acceptable and that 15 visits for physical therapy is the maximum acceptable. The committee recommends that a reasonable payment in this case would be $210.00, which includes $10 per visit to the physician and $10 per visit for the therapy. (The total billed in this case was $760.00.)"

The recommendation of the committee **was approved.**

Medical Advances Institute

Dr. James L. Henry reported on four meetings involving Medical Advances Institute. His report was received for information.

Federal Legislation

Mr. Edgar reported that legislation to authorize establishment of an armed forces medical school, with possible additional schools, has been passed and signed into law by the President.

State Legislation

Council directed the staff to prepare legislation for introduction into the 110th Ohio General Assembly to mandate use of a fiscal agent to operate the Medicaid Program.

Mr. Rader reported on deliberations of the Controlling Board in the State of Ohio with regard to Medicaid funds and Mr. Edgar reported on proposed legislation for financing and organization of health districts.

Mr. William Lee, Administrator of the Ohio State Medical Board, addressed the Council concerning legislative proposals felt necessary by the Ohio State Medical Board. Subsequent to his report, the Council **approved in principle** legislation to modify Section 4731.15 of the Ohio Revised Code with regard to limited practitioners and 4731.292 with regard to citizenship for those obtaining a limited certificate. The staff and the legal counsel were authorized to cooperate with the Medical Board in developing such legislation.

Mr. Lee announced that the Board now has a full-time Attorney General assigned to it.

Personal Liability Insurance

An improvement in the personal liability insurance for Council and Delegates of the Ohio State Medical Association was discussed by Mr. Campbell and **was approved** by the Council.

Family Practice Legislation

Dr. Harry A. Killian, President of the Ohio Academy of Family Physicians, addressed the Council concerning proposed legislation to make money available to medical schools which would be used for establishing Departments of Family Practice. The proposal was taken under advisement by the Council.

Clinics

A communication from Guernsey County with regard to several clinics in operation there was referred to the officers for discussion with Dr. Cashman.

Health Careers of Ohio

With regard to a question posed by Mr. Rader, Council asked that he obtain information with regard to the survey on the physician's assistant.

American College of Emergency Physicians

A communication requesting OSMA recognition of the Ohio Chapter of the American College of Emergency Physicians was referred to the Committee on Long Range Planning for study and report.

Hospital Emergency Rooms

A communication from Highland County concerning the hospital emergency room situation there was referred to the Joint Committee of the Ohio Hospital Association, Ohio State Medical Association and Ohio Osteopathic Association of Physicians and Surgeons and to the First District Councilor.

Greetings to Miss Winzenried

The Council extended best wishes to Miss Hazel Winzenried for a speedy recovery.

Next Meeting of the Council

The next meeting of the Council was set for December 16-17, 1972.

ATTEST: Hart F. Page
Executive Director

Notice To All Members!

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:

Mail your dues immediately to the Secretary-Treasurer of Your County Medical Society.

OSMA dues are $65.00. AMA membership dues are $110.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer. Ohio Medical Political Action Committee—American Medical Political Action Committee dues are $25. OMPAC-AMPAC dues are voluntary and not tax deductible.

Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. **Make Check Payable To Your County Medical Society.**

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Your local Secretary-Treasurer will forward your OMPAC-AMPAC dues to OMPAC Headquarters.

As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA, Today's Health,* and the *American Medical News.*

The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should make his wishes known to the secretary-treasurer of his County Medical Society. After exemption has once been established, the member is automatically carried over from year to year, unless the status changes.

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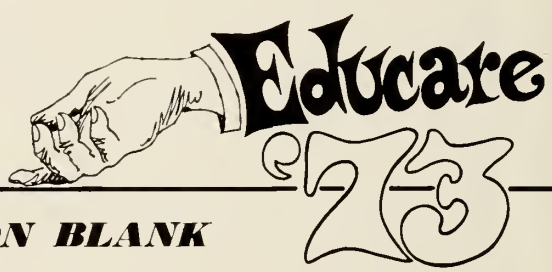
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_____



1973 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1973 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be Monday through Wednesday, May 7, 8 and 9.

Mail applications to the attention of Jerry J. Campbell, Exhibit Manager, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1973 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 7, 8 and 9

1. Title of Exhibit:_____
2. Name(s) of Exhibitor(s):_____

   Institution (If desired):_____

   City_____
3. Do you have a built-in exhibit?_____
4. Booth Requirements: Back wall _____ All side walls are 6′ deep
   (indicate footage)
5. Description of Exhibit: (Attach 200 word description to this blank)

Deadline For Filing Applications, February 1, 1973

Obituaries

Jason William Albaugh, M.D., Stockport; Chicago College of Medicine and Surgery, 1911; aged 90; died October 30; member of the OSMA and AMA; general practitioner of long standing in the Mingo Junction area; retired in recent years.

Donavin Albert Baumgartner, Sr., M.D., Cleveland; Western Reserve University School of Medicine, 1925; aged 74; died October 4; member of OSMA and AMA; practitioner for some 40 years on the East Side of Cleveland, specializing in internal medicine.

Frederick John Bierkamp, M.D., Youngstown; University of Michigan Medical School, 1909; aged 87; died October 10; member of OSMA and AMA; retired in 1965 after practice of long standing in Youngstown; veteran of World War I.

Carl N. Brudzynski, M.D., Cleveland; Western Reserve University School of Medicine, 1944; aged 53; died October 7; member of OSMA and AMA; practitioner in the Garfield Heights area and physician for the local police and fire departments; also physician for the Garfield Heights athletic teams; veteran of World War II.

Benjamin Julius Chazin, M.D., Dayton; State University of New York, Downstate Medical Center, 1936; aged 71; died September 28; member of OSMA and AMA; associated for 27 years with the Veterans Administration Center in Dayton, where he was chief of the domiciliary clinic; veteran of World War II.

Forest William Cox, M.D., Ft. Lauderdale, Fla.; University of Pennsylvania School of Medicine, 1925; aged 79; died October 17; former member of OSMA; practitioner in Dayton for 20 years before moving to Florida in 1952.

Virgil G. Damon, M.D., New York City; Ohio State University College of Homeopathic Medicine, 1921; aged 77; died July 12; native of Ohio and practitioner for many years in New York. His father was Dr. George Damon who practiced for many years in Medina before his death in 1927.

Sophia Bertha Dauch, M.D., Grosse Pointe, Mich.; Medical College of Ohio, Cincinnati, 1908; aged 94; died in August; former member of OSMA; practitioner of long standing in Cincinnati; moved to Grosse Pointe several years ago.

James Rider Donaldson, M.D., Miraj, India; Western Reserve University School of Medicine, 1947; aged 52; died October 10; as a medical missionary for the Presbyterian Church, was deputy superintendent of Miraj Medical Center in India. He was affiliated with the Presbytery in the Youngstown area.

Charles Wesley Edwards, M.D., Columbus; Ohio State University College of Medicine, 1931; aged 67; died October 4; member of OSMA, AMA, and American Academy of Family Physicians; practitioner of long standing in Columbus; veteran of World War II.

Rodolfo Frank Fasoli, M.D., Medina; Medical College of Virginia, 1932; aged 64; died October 6; member of OSMA and AMA; practitioner in the Brunswick and Medina areas for nearly 40 years; member of the Medina County Health Board.

Jonathan Paul Gibbel, M.D., Greenville; University of Illinois College of Medicine, 1926; aged 76; died September 23; member of OSMA, AMA, the American Society of Anesthesiologists, and the International Anesthesia Research Society; practitioner in the Darke County area since 1930, first having his office in Gettysburg and since 1950 in Greenville; specialist in anesthesiology.

Clarence Leo Johnson, M.D., Kenton; University of Iowa College of Medicine, 1925; aged 74; died September 28; member of OSMA and AMA; general practitioner for some 40 years in the Kenton area.

William Alfred Neill, M.D., Toledo; University of Pennsylvania School of Medicine, 1917; aged 82; died October 2; member of OSMA and AMA; Fellow, American College of Surgeons, and International College of Surgeons; surgeon in the Toledo area for many years and founder of the

Toledo Clinic; former active and reserve officer in the U.S. Navy; past president of the Academy of Medicine of Toledo.

Burrell Russell, M.D., New Philadelphia; Kansas City University of Physicians and Surgeons, 1923; aged 83; died October 9; member of OSMA and AMA; general practitioner of some 46 years' standing in the New Philadelphia area.

Laurence Segal, M.D., Surfside, Fla.; Medico-Chirurgical College of Philadelphia, 1915; aged 82; died October 25; member of OSMA and AMA; general practitioner of long standing in Youngstown before his retirement several years ago.

James Halford Warren, M.D., Columbus; Ohio State University College of Medicine, 1915; aged 83; died October 22; former member of OSMA and AMA; diplomate, American Board of Internal Medicine; practitioner of long standing in Columbus, specializing in internal medicine; formerly on the faculty at the OSU College of Medicine; past president of the Academy of Medicine of Columbus and Franklin County; veteran of World War I. Dr. James V. Warren, chief of Department of Medicine at OSU, is his son.

The Division of Pediatric Cardiology at the University of Miami (Florida) will sponsor a symposium on "Controversial Issues in Pediatric Cardiology, 1973" to be held in Key Biscayne, March 19-22. Direct inquiries to Division of Continuing Education, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA (Cleveland)
A. Scott Earle
Aaron E. Feldman
Mark R. Levine
Sidney L. Marvin
Sanyogita Srinivas
Claude S. Tabatabai

FRANKLIN (Columbus)
Robert M. Baldwin
Ralph R. Ballenger

HAMILTON (Cincinnati)
Kenneth B. Albers
Helen M. Dean

LORAIN
Gunvantkumar O. Desai
Oberlin
Victorino M. Fusilero
Lorain
Sopon Nakpairat
Oberlin
Ernesto R. Punsalan
Elyria

LUCAS (Toledo)
Ali Esenler
Nevin Esenler

MIAMI
Victor M. Rivera
Troy

MONTGOMERY
Thomas J. Sorauf
Dayton

SCIOTO
Paul Keith Steele
Wheelersburg

TRUMBULL
Rodolfo P. Ballesteros
Warren

Woman's Auxiliary Highlights

By Mrs. S. L. Meltzer, Publicity Chairman
2442 Dorman Drive, Portsmouth 45662

CHRISTMAS is synonymous with giving—and thinking of others. It brings into sharp focus all that is good in man—his thought for others, his willingness to share, his desire to help. Would that the spirit of Christmas were manifested every day of the year!

Perhaps to no one time of the year does the auxiliary project of International Health belong more than to this Holiday Season. It ties in with the Christmas observance in a very special, very touching way. This is a rapidly shrinking, ever interdependent world in which we live. Pain and suffering have no regard for race, creed, color or geographic location. "Doing" for others is what counts. Isn't that an integral part of "Peace On Earth, Good Will Toward Man"? To be practiced not only at Christmas but the whole year long?

I like to think of our state International Health chairman as the Auxiliary's day-in-and-day-out Santa. She is Mrs. Howard E. Smith of Lucas County and assuredly Carolinea is the most attractive Santa around! She has many, many helpers throughout Ohio, those county International Health chairmen—the "grass roots" of the whole important project. These women spark Project Hope and World Medical Relief into an outstanding activity of Ohio's doctors' wives.

What better gift could each county auxiliary give this Christmas of 1972 than an organizational membership in Project Hope? It doesn't have to involve a large sum of money—it can be as little as ten dollars or as much as the local treasury can stand. . . . Carolinea Smith urges that every county group be such an organizational member this year. Wouldn't you consider this the ideal time to go about being just that?

Remember World Medical Relief as another project belonging in a sense to the Christmas season, but belonging equally to every day of the year. While the Christmas spirit is in the air, consider this relief project a worthwhile candidate for special gifts. Millions of dollars in drugs, supplies and equipment have been sent for some time now, yet there is never enough to meet the urgent needs. Only as our medical community keeps World Medical Relief supplied, will it be possible to continue sending desperately needed items to the doctors and nurses and others working so unselfishly all over the world. (For those interested in knowing what articles are needed, Mrs. Smith will be glad to send a mimeographed list of such items. Her address is 2144 Fordway Drive, Toledo 43606.) The offices of World Medical Relief are at 11745 12th Street, Detroit, Michigan 48206.

Fall Conference

It was a jam-packed day—Tuesday, October 24 at the Hospitality Motor Inn in Columbus. I doubt that anyone could have left this year's Fall Conference without feeling that she had been offered much—and had learned much.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Louis Loria
Box 331, R. D. 1
Bristolville, 44402

President-Elect
Mrs. Karl Ulicny
864 Highland Ave.
Salem, 44460

Past President
Mrs. Russell L. Wiessinger
2280 W. Wayne St.
Lima, 45805

First Vice-President
Mrs. Jack Weiland
313 Rumson Dr.
Englewood, 45322

Second Vice-President
Mrs. Howard E. Smith
2144 Fordway
Toledo, 43606

Third Vice-President
Mrs. S. J. Glueck
3405 Kappel Dr.
Springfield, 45503

Recording Secretary
Mrs. H. I. Humphrey
389 S. Drexel Ave.
Columbus, 43209

Corresponding Secretary
Mrs. T. A. Russell
116 Bonnie Brae N. E.
Warren, 44483

Treasurer
Mrs. Paul Hahn
122 Moore Ave.
New Philadelphia, 44663

Beginning at 9:15 a.m. with the showing of the film "They're Leaving Us All The Time" to the talk by Mrs. Emily Leedy on "Legislation for Women and What Our Future Role Can Be" at 3:10 p.m., the day's program was chock-full of food for thought and for action.

The keynote speech was given at 10:00 a.m. by Robert Kaplan, Ph.D., professor of health education at Ohio State University. Following Dr. Kaplan's talk and question and answer period, Mrs. Robert E. Krone, state nutrition chairman and herself a dietitian, discussed the "What and Now" of that important subject. The luncheon speaker was Mrs. Malachi W. Sloan, II, North Central Regional Legislation chairman, who detailed the services rendered by the National Auxiliary for the benefit of the state and county groups. And then, of course, there were the special workshop sessions without which no Fall Conference would be complete. Such workshops included safety, health education, drugs and venereal diseases, Auxiliary News, a "crash course" in journalism, International Health, health manpower, membership, AMA-ERF and legislation.

Here are just a few of the important quotes from some of the day's guest speakers: Mrs. John Sugg (who narrated the film "They're Leaving Us All the Time" and whose young son had been killed by a drunken driver): "Society must face up to its responsibilities; we only get what we demand in the way of law enforcement. . . . Thomas Jefferson said that the execution of the laws is far more important than the making of them. . . . how does a mother feel when the woman who killed her son receives a suspended sentence, laughs in that mother's face and then later is once again arrested for drunken driving? Such cruel ironies happen all the time. . . ."

Dr. Robert Kaplan: "The world is changing so rapidly that we are having a hard time keeping up with those changes. . . . we cannot teach some**thing** unless we teach some**one**. . . . you cannot respect someone else unless you respect yourself. . . . there is an eroding away of self-esteem. . . . health is broader than the physical things we deal with; it is equally concerned with behavior. . . . Better schools are playing the role of reflecting attitudes of behavior. . . . health education has to become, hopefully, more concerned with one's life. . . . education has health education built into it. . . ."

Mrs. Robert E. Krone: "Food itself is so involved with how we feel and look that we cannot separate it from all the psychological factors bound up with nutrition. . . . current interest in nutrition is good but there is a lot of misinformation and food faddism that make for exaggerated claims; the public must learn to separate fact from fancy. . . . there is no country where more food is wasted than in this country, and where more health conditions are the result of excesses. . . . auxiliary members must become involved as catalysts. . . ."

Mrs. W. F. Stevenson and Mrs. Wade A. Bacon of Columbiana County served as the Conference chairmen, working in close cooperation with Mrs. Karl Ulicny, state president-elect and Mrs. Louis Loria, state president.

A Worthy Successor

It's not easy to fill the shoes of two predecessors like Frankie Fry and Jane Sloan who served as outstanding state legislative chairmen. (Of course, Jane is still serving on the national level.) Fortunately for us on the state level, the new legislative chairman by the name of Mrs. S. S. Pfahl, of Huron, promises to be another candidate for our own legislative Hall of Fame. She is dedicated, dynamic and determined and she has a very persuasive and convincing "way" about her.

In October, Fifi Pfahl attended the National Auxiliary workshop in Kansas City. "I was ignited by three people," she says—"Dr. Hoyt Gardner, chairman of the Board of Directors of AMPAC; his wife, Rose Gardner, national legislative chairman; and our own Mrs. Malachi W. Sloan II, North Central regional chairman." Here are her further remarks on what was stressed in Kansas City:

"The message from these knowledgeable people is an urgent one because the practice of medical care is not going to be determined in the halls of our medical schools or doctors' offices, but in the halls of the Legislature in 1973. What does this mean? It means that we ALL have to do what we can as individuals in supporting organized medicine to help get friends of medicine elected to our legislative bodies. For it seems as though the only hope we have of a voice in what the future direction of medical and health care is going to take will be through the friend in the halls of our Legislature. One might say it all boils down to practical politics. Our legislation cannot be effective unless we first are effective at the polls. (As this reporter presents Mrs. Pfahl's Kansas City report BEFORE the November 7 election, she cannot help but fervently hope that, as you are reading this in December, there were many friends of medicine elected on November 7!)

To continue with Mrs. Pfahl's report: "Secondly, it means we have to be educated so that we can inform others with accurate information. I believe that there should be an active, enthusiastic legislative chairman in every county auxiliary. Next to membership, legislation should rank

second in priority. For whatever the election results, we must keep on working, educating and trying. . . .

"I would like to paraphrase a statement by Dr. Gardner—that when the history of this changing age of medicine is written, it will be said that the doctors and their wives were active citizens and patriots, for they cared enough and they did make the difference."

The National Auxiliary has provided local groups with a package program called "Legislative Effort Group System" (or as it is more popularly called "LEGS") to help the local legislation chairman be the "legs" to bring to every doctor's wife information on the political and legislative developments in this country as they affect the medical and health care system. In the next issue of *The Journal,* I shall highlight the "LEGS" program and activities.

Around the State

The **Crawford County** auxiliary held a festive luncheon meeting on October 24 to celebrate the fiftieth anniversary of the National Auxiliary and to honor the local group's two active charter members—Mrs. Darrel D. Bibler of Bucyrus and Mrs. Malcolm E. Switzer of Galion. A sterling silver charm, suitably engraved, was presented to each woman.

Mrs. Bibler served on the organization committee for the county when it was started on December 3, 1940 and served as its first vice-president. She was president in 1944 and 1946, again vice-president in 1950 and 1952. She has also served on many committees including program and public relations.

Mrs. Switzer has served as auxiliary secretary and treasurer and on innumerable committees. She is a native of Scotland, coming to this country as a "wee ane." Special recognition was given Mrs. Jack Arnold of Bucyrus, a twenty-five year member, who has served as president, vice-president, secretary and on many committees. Mrs. Thomas K. Huggins, Crawford president, presented Mrs. Arnold with a basket of fruit and a bittersweet arrangement.

The luncheon table favors were white program booklets with the fiftieth anniversary seal on the cover page, made by Mrs. Don E. Ingham, vice-president and AMA-ERF chairman. Each member received a fiftieth anniversary goblet. Mrs. Huggins gave a history of the national auxiliary. Mrs. Ingham discussed the history of AMA-ERF. Mrs. Johnson Chow, secretary-treasurer, presented a history of the Crawford auxiliary and its activities. Top priority is the group's student loan program in which money is lent, interest-free, to any health career student. At the present time, this hard-working local group is supporting four such students.

The committee in charge of the anniversary celebration included: Mrs. Robert L. Solt, Jr., chairman, Mrs. John K. Kurtz and Mrs. William R. Oris.

Just Like Christmas!

That's how Dr. Glen R. Driscoll, president of the University of Toledo, must have felt recently when he received a $2000 check from the **Lucas County** auxiliary! Only it was the month of October and it was a new kind of auxiliary gift. A paramedical grant and scholarship fund has been established at the university—the first of its kind. The money is to be used for financial assistance to students enrolled in the health specialty or paramedical programs at the university. Graduate students who plan to do additional work in a health-related field also are eligible for assistance. The Auxiliary plans to add at least a minimum of $600 a year to the fund—and, hopefully, much more!

Mrs. Burton Nelson, Lucas County president, who presented the check to Dr. Driscoll, explained that the auxiliary designed this open-ended endowment with "a broad base in order to give more people an opportunity to use it." The presentation took place at the group's first luncheon meeting of the year at the Academy of Medicine building in Toledo.

One of the means the auxiliary uses to provide funds for its undertakings such as the grant-scholarship is the monthly luncheon-meeting. No caterers are involved, according to Mrs. Daniel R. Sullivan, health manpower chairman. A committee of women organize and prepare the meals in the kitchen of the Academy building. The October luncheon was headed by Mrs. J. Keith Welborn and Mrs. Joseph Roshe and 105 luncheons were served!

Mrs. Welborn obtained the recipes from the Auberge le Vieux St. Gabriel, a Montreal restaurant. There was *boeuf Gabriel, salad de concombre et tomate* and *creme renversee.* (I wouldn't dream of translating into English — it might spoil the effect. . . .) Dr. Driscoll liked the dessert so well, according to Mrs. Nelson, that he asked for the recipe.

Following the group's business meeting, Joyce Feurring and Evelyn Orbach, Detroit dramatists, presented sketches from "Our Town," "Barefoot in the Park" and "Anastasia."

Merry Christmas — Everybody!

May the gifts of love, happiness and good health be yours this Holiday Season—and every day thereafter.

Iron therapy for anemia is almost as old as history itself



Celsus's empirical use of iron

Aulus Cornelius Celsus recommended an unusual form of iron therapy for the treatment of enlarged spleens—the oral administration of water that blacksmiths had used for dousing white-hot iron.

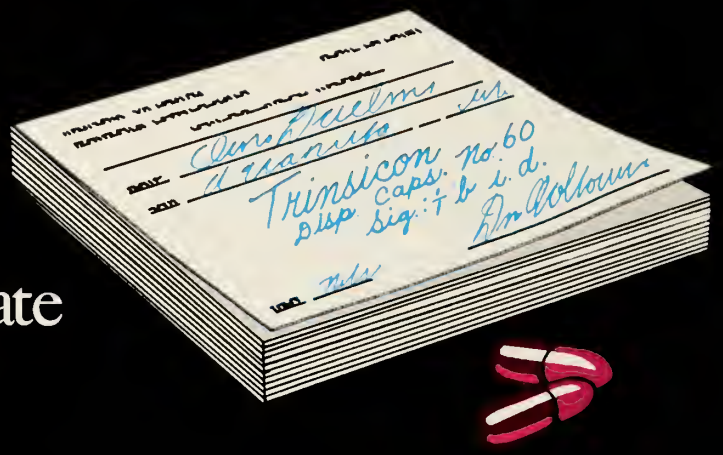
For more modern anemia therapy

Trinsicon®

Hematinic Concentrate with Intrinsic Factor

(See reverse side for prescribing information.)

Trinsicon®
Hematinic Concentrate with Intrinsic Factor



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	240 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	0.5 mg.

(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)

Indications: Trinsicon is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hematopoietic factors that are known to be important are present in the recommended daily dose.

Vitamin B_{12} with Intrinsic Factor—When secretion of intrinsic factor in gastric juice is inadequate or absent (e.g., in Addisonian pernicious anemia or after gastrectomy), vitamin B_{12} in physiological doses is absorbed poorly, if at all. The resulting deficiency of vitamin B_{12} leads to the clinical manifestations of pernicious anemia. Similar megaloblastic anemias may develop in fish tapeworm (*Diphyllobothrium latum*) infection or after a surgically created small-bowel blind loop; in these situations, treatment requires freeing the host of the parasites or bacteria which appear to compete for the available vitamin B_{12}. Strict vegetarianism and malabsorption syndromes may also lead to vitamin B_{12} deficiency. In the latter case, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient.

Potency of intrinsic factor concentrates is determined physiologically, i.e., by their use in patients with pernicious anemia. The liver-stomach concentrate with intrinsic factor and the vitamin B_{12} contained in two Pulvules Trinsicon provide 1½ times the minimum amount of therapeutic agent which, when given daily in an uncomplicated case of pernicious anemia, will produce a satisfactory reticulocyte response and relief of anemia and symptoms.

Concentrates of intrinsic factor derived from hog gastric, pyloric, and duodenal mucosa have been used successfully in patients who lack intrinsic factor. For example, Fouts *et al.* maintained patients with pernicious anemia in clinical remission with oral therapy (liver extracts or intrinsic factor concentrate with vitamin B_{12}) for as long as twenty-nine years.

After total gastrectomy, Ficarra found multifactor preparations taken orally to be "just as effective in maintaining blood levels as any medication that has to be administered parenterally." His study was based on twenty-four patients who had survived for five years after total gastrectomy for cancer and who had been taking two Pulvules Trinsicon daily.

Folic Acid—Folic acid deficiency is the immediate cause of most, if not all, cases of nutritional megaloblastic anemia and of the megaloblastic anemias of pregnancy and infancy; usually, it is also at least partially responsible for the megaloblastic anemias of malabsorption syndromes, e.g., tropical and nontropical sprue.

It is apparent that in vitamin B_{12} deficiency (e.g., pernicious anemia), lack of this vitamin results in impaired utilization of folic acid. There are other evidences of the close folic acid-vitamin B_{12} interrelationship: (1) B_{12} influences the storage, absorption, and utilization of folic acid, and (2), as a deficiency of B_{12} progresses, the requirement for folic acid increases. However, folic acid does not change the requirement for vitamin B_{12}.

Iron—A very common anemia is that due to iron deficiency. In most cases, the response to iron salts is prompt, safe, and predictable. Within limits, the response is quicker and more certain to large doses of iron than to small doses.

Each Pulvule Trinsicon furnishes 110 mg. of elemental iron (as ferrous fumarate) to provide a maximum response.

Ascorbic Acid—Vitamin C plays a role in anemia therapy. It augments the conversion of folic acid to its active form, folinic acid. In addition, ascorbic acid promotes the reduction of ferric iron in food to the more readily absorbed ferrous form. Severe and prolonged vitamin C deficiency is associated with an anemia which is usually hypochromic but occasionally megaloblastic in type.

Contraindications and Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin-B_{12}-deficiency states, such as pernicious anemia. Indeed, the use of folic acid in large doses in pernicious anemia without adequate vitamin B_{12} may result in hematologic remission but neurological progression.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500 and in Identi-Dose® (unit dose medication, Lilly) in boxes of 100. [000971]

Trinsicon®
Hematinic Concentrate with Intrinsic Factor
A Comprehensive Hematinic

Additional information available to the profession on request.

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Should old depressives be forgot?

geriatric depressive.
Unable to concentrate he tends
ake little interest in the affairs
und him. His reactions are slow
delayed. He speaks very little.
en he does, it's mostly to com-
n of his insomnia, fatigue, or
stipation.

One way of relieving depression in the geriatric patient is with Tofranil.

Please read the prescribing information for details of usage (lower dosages are recommended for elderly patients and adolescents), precautions, warnings, contraindications, adverse experiences, and dosage recommendations. It is summarized below.

Tofranil® Geigy
imipramine hydrochloride USP



nil® imipramine hydrochloride USP

raindications: The concomitant use of this agent monoamine oxidase inhibiting (M.A.O.I.) com- ds is contraindicated. Hyperpyretic crises or e convulsive seizures may occur. Potentiation of rse effects can be serious or even fatal. An interval least 14 days after M.A.O.I. therapy has been ntinued should be allowed before this drug may bstituted. Initial dosage should be low, increases ld be gradual, and the patient's progress should refully observed. The drug is also contraindicated uring the acute recovery period after myocardial ction, (b) in patients with known hypersen- ity to the drug. Cross-sensitivity to other dibenz- ine compounds should be kept in mind.

Warnings: *Usage in Pregnancy:* Safe use of ramine during pregnancy and lactation has not established; therefore, in administering the drug egnant patients, nursing mothers, or women of bearing potential, the potential benefits must be hed against the possible hazards. Animal repro- ion studies have yielded inconclusive results. e have been clinical reports of congenital mal- ation associated with the use of this drug, but a al relationship has not been confirmed.

Extreme caution should be used when this drug en to:

tients with cardiovascular disease because of the ssibility of conduction defects, arrhythmias, ocardial infarction, strokes and tachycardia;

tients with increased intraocular pressure, history urinary retention, or history of narrow-angle aucoma because of the drug's anticholinergic operties;

perthyroid patients or those on thyroid medica- n because of the possibility of cardiovascular xicity;

tients with a history of seizure disorder because is drug has been shown to lower the seizure reshold;

tients receiving guanethidine or similar agents ce imipramine may block the pharmacologic fects of these drugs.

Usage in Children: Pending evaluation of results clinical trials in children, the drug is not recom- led for use in patients under twelve years of age.

Since the drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as operating an automobile or machinery, the patient should be cautioned accordingly.

Precautions: Because of the possibility of suicide in seriously depressed patients, careful supervision during the early phase of treatment is necessary and hospitalization may be required. Prescriptions should be written for the smallest amount feasible.

Hypomanic or manic episodes may occur, particularly in patients with cyclic disorders. Such reactions may necessitate discontinuation of the drug. If needed, imipramine may be resumed in lower dosage when these episodes are relieved. Administration of a tranquilizer may be useful in controlling such episodes.

Prior to elective surgery, imipramine should be discontinued for as long as the clinical situation will allow.

An activation of the psychosis may occasionally be observed in schizophrenic patients and may require reduction of dosage and the addition of a phenothiazine.

In occasional susceptible patients or in those receiving anticholinergic drugs (including antiparkinsonism agents) in addition, the atropine-like effects may become more pronounced (e.g. paralytic ileus). Close supervision and careful adjustment of dosage is required when this drug is administered concomitantly with anticholinergic or sympathomimetic drugs.

Patients should be warned that the concomitant use of alcoholic beverages may be associated with exaggerated effects.

Both elevation and lowering of blood sugar levels have been reported.

Concurrent administration of imipramine with electroshock therapy may increase the hazards; such treatment should be limited to those patients for whom it is essential.

Adverse Reactions: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue), drug fever, cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

How Supplied: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration. (B)98-146-850-H (7/71)

For complete details, including dosage, please refer to the full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TO 8575



When you select this familiar antibiotic for IV infusion you have available a broad dosage range that hospitalized patients may need.

Intravenous Lincocin (lincomycin hydrochloride, Upjohn), with its 1.2 to 8 grams/day dosage range, covers many serious and even life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. Lincocin IV therefore can be as useful in your hospitalized patients as its IM use has proved to be in your office patients. As with all antibiotics, *in vitro* susceptibility studies should be performed.

1.2 to 8 grams/day IV dosage range: Most hospitalized patients with uncomplicated pneumonias respond satisfactorily to 1.2 to 1.8 grams/day of Lincocin IV. These doses may have to be increased for more serious infections. In life-threatening situations as much as 8 grams/day has been administered intravenously to adults.

In usual IV doses, Lincocin (lincomycin hydrochloride, Upjohn) should be diluted in 250 ml or more of normal saline solution or 5% glucose in water. But when 4 grams or more per day is given, Lincocin should be diluted in not less than 500 ml of either solution, and the rate of administration should not exceed 100 ml/hour. Too rapid intravenous administration of doses exceeding 4 grams may result in hypotension or, in rare instances, cardiopulmonary arrest.

Effective gram-positive antibiotic: Lincocin IV is effective in respiratory tract, skin and soft-tissue, and bone

infections caused by susceptible strains of pneumococci, streptococci, and staphylococci, including penicillin-resistant strains. Staphylococcal strains resistant to Lincocin (lincomycin hydrochloride, Upjohn) have been recovered. Before initiating therapy, culture and susceptibility studies should be performed. Lincocin has proved valuable in treating patients hypersensitive to penicillin or cephalosporins, since Lincocin does not share antigenicity with these compounds. However, hypersensitivity reactions have been reported, some of these in patients known to be sensitive to penicillin.

Well tolerated at infusion site: Lincocin intravenous infusions have not produced local irritation or phlebitis, when given as recommended. Lincocin is usually well tolerated in patients who are hypersensitive to other drugs. Nevertheless, Lincocin should be used cautiously in patients with asthma or significant allergies.

In patients with impaired renal function, the recommended dose of Lincocin should be reduced to 25–30% of the dose for patients with normal kidney function. Its safety in pregnant patients and in infants less than one month of age has not been established.

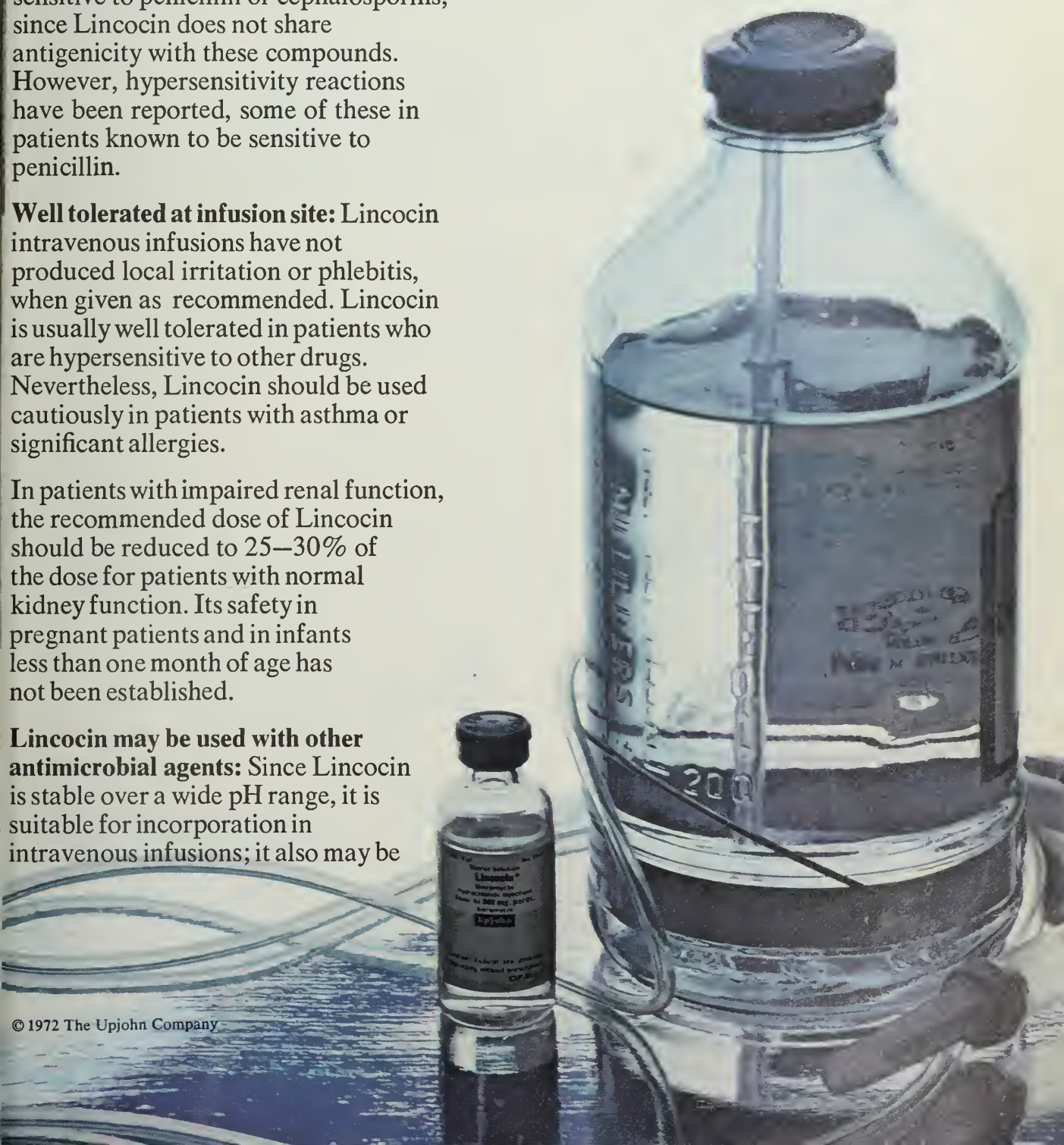
Lincocin may be used with other antimicrobial agents: Since Lincocin is stable over a wide pH range, it is suitable for incorporation in intravenous infusions; it also may be administered concomitantly with other antimicrobial agents when indicated. However, Lincocin should not be used with erythromycin, as *in vitro* antagonism has been reported.

Lincocin®

Sterile Solution (300 mg per ml)

(lincomycin hydrochloride, Upjohn)

For further prescribing information, please see following page.



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Sterile Solution (300 mg. per ml.)

Lincocin®

(lincomycin hydrochloride, Upjohn)

Up to 8 grams per day by IV infusion for hospitalized patients with life-threatening infections. Lincocin is effective in infections due to susceptible strains of streptococci, pneumococci, and staphylococci. As with all antibiotics, *in vitro* susceptibility studies should be performed.

Each preparation contains:	Lincomycin hydrochloride monohydrate equivalent to lincomycin base
250 mg Pediatric Capsule	250 mg
500 mg Capsule	500 mg
*Sterile Solution per 1 ml	300 mg
Syrup per 5 ml	250 mg

*Contains also: Benzyl Alcohol 9 mg; and, Water for Injection—q.s.

Lincocin (lincomycin hydrochloride) is indicated in infections due to susceptible strains of staphylococci, pneumococci, and streptococci. *In vitro* susceptibility studies should be performed. Cross resistance has not been demonstrated with penicillin, ampicillin, cephalosporins, chloramphenicol or the tetracyclines. Some cross resistance with erythromycin has been reported. Studies indicate that Lincocin does not share antigenicity with penicillin compounds.

CONTRAINDICATIONS: History of prior hypersensitivity to lincomycin or clindamycin. Not indicated in the treatment of viral or minor bacterial infections.

WARNINGS: *CASES OF SEVERE AND PERSISTENT DIARRHEA HAVE BEEN REPORTED AND HAVE AT TIMES NECESSITATED DISCONTINUANCE OF THE DRUG. THIS DIARRHEA HAS BEEN OCCASIONALLY ASSOCIATED WITH BLOOD AND MUCUS IN THE STOOLS AND HAS AT TIMES RESULTED IN AN ACUTE COLITIS. THIS SIDE EFFECT USUALLY HAS BEEN ASSOCIATED WITH THE ORAL DOSAGE FORM BUT OCCASIONALLY HAS BEEN REPORTED FOLLOWING PARENTERAL THERAPY.* A careful inquiry should be made concerning previous sensitivities to drugs or other allergens. Safety for use in pregnancy has not been established and Lincocin (lincomycin hydrochloride) is not indicated in the newborn. Reduce dose 25 to 30% in patients with severe impairment of renal function.

PRECAUTIONS: Like any drug, Lincocin should be used with caution in patients having a history of asthma or significant allergies. Overgrowth of nonsusceptible organisms, particularly yeasts, may occur and require appropriate measures. Patients with pre-existing monilial infections requiring Lincocin therapy should be given concomitant antimonilial treatment. During prolonged Lincocin therapy, periodic liver function studies and blood counts should be performed. Not recommended (inadequate data) in patients with pre-existing liver disease unless special clinical circumstances indicate. Continue treatment of β-hemolytic streptococci infections for 10 days to diminish likelihood of rheumatic fever or glomerulonephritis.

ADVERSE REACTIONS: *Gastrointestinal*—Glossitis, stomatitis, nausea, vomiting. Persistent diarrhea, enterocolitis, and pruritus ani. *Hemopoietic*—Neutropenia, leukopenia, agranulocytosis, and thrombocytopenic purpura have been reported. *Hypersensitivity reactions*—Hypersensitivity reactions such as angioneurotic edema, serum sickness, and anaphylaxis have been reported, sometimes in patients sensitive to penicillin. If allergic reaction occurs, discontinue drug. Have epinephrine, corticosteroids, and antihistamines available for emergency treatment. *Skin and mucous membranes*—Skin rashes, urticaria, vaginitis, and rare instances of exfoliative and vesiculobullous dermatitis have been reported. *Liver*—Although no direct relationship to liver dysfunction is established, jaundice and abnormal liver function tests (particularly serum transaminase) have been observed in a few instances. *Cardiovascular*—Instances of hypotension following parenteral administration have been reported, particularly after too rapid IV administration. Rare instances of cardiopulmonary arrest have been reported after too rapid IV administration. If 4.0 grams or more administered IV, dilute in 500 ml of fluid and administer no faster than 100 ml per hour. *Special senses*—Tinnitus and vertigo have been reported occasionally. *Local reactions*—Excellent local tolerance demonstrated to intramuscularly administered Lincocin (lincomycin hydrochloride). Reports of pain following injection have been infrequent. Intravenous administration of Lincocin in 250 to 500 ml of 5% glucose in distilled water or normal saline has produced no local irritation or phlebitis.

HOW SUPPLIED: *250 mg* and *500 mg* Capsules—bottles of 24 and 100. *Sterile Solution, 300 mg per ml*—2 and 10 ml vials and 2 ml syringe. *Syrup, 250 mg per 5 ml*—60 ml and pint bottles.

For additional product information, consult the package insert or see your Upjohn representative.

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The Upjohn Company
Kalamazoo, Michigan 49001

Upjohn

Continuing Education Opportunities for Physicians in Ohio

Surgical Seminars — Medical College of Ohio at Toledo and Northwestern Ohio Institute for Continuing Medical Education; one hour a day, one day a week, for 88 weeks; dates on request.

Clinical Days on Emergency Care — 80 hours of instruction on 20 separate days, September to June; Medical College of Ohio at Toledo, 945 S. Detroit Ave., Toledo 43614.

Introductory Course in Nuclear Medicine for Physicians — Nuclear Medicine Institute, 6760 Mayfield Rd., Cleveland 44124; five-day courses; dates upon request.

January

Electrolyte and Acid-Base Therapy for the Clinician — Akron City Hospital, 525 E. Market St., Akron 44309; January 10.

Anesthesia in Obstetrics and Gynecology — Sponsored by the Cleveland Society of Obstetricians and Gynecologists; at the Cleveland Clinic, January 10, at 3:00 p.m. with a dinner at 6:30 and an evening meeting; Speaker, Charles Flowers, M.D., professor and chairman of the Department of Obstetrics and Gynecology, University of Alabama; contact, Kathryn E. Hoffman, M.D., 806 Rose Bldg., Cleveland 44115.

Association of Physicians of the State of Ohio — Quarterly meeting and program, January 12 at the Mt. Vernon State Institute; contact Virginia S. Edwards, M.D., Secretary, 347 Lexington Ave., Mansfield 44907.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Managing the Complicated Surgical Patient — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 17-18.

Medical Aspects of Drug Addiction in Dayton — Veterans Administration Center, 4100 W. Third St., Dayton 45428; January 19, 2:30 to 4:30 p.m.; presentation by Barrett H. Bolton, M.D., director of education, Department of Internal Medicine, Miami Valley Hospital, Dayton; contact Hassan Mehbod, M.D., at the center.

Treatment of Diseases of the Esophagus — University of Cincinnati College of Medicine, January 25; contact Office of CONMED, 114 Medical College Building, Cincinnati 45219.

Gastroenterology — Ohio State University College of Medicine, January 31; contact Center for Continuing Education, 320 W. Tenth Ave., Columbus 43210.

Medical Progress for the Family Physician — Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106; January 31- February 1.

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Educational Opportunities in Ohio — *Continued*

February

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

Advanced Rhinoplasty — February 5-7 (Hawaii)

Infectious Diseases — February 7, Center for Tomorrow

ENT Conference — February 15, Stouffer's University Inn

Group Psychotherapy — Fridays, February 16 through May 4, Center for Tomorrow

Electromyography XII — February 19-22, Dodd Hall and Stouffer's Inn

Orthopaedic Problems — February 21, Center for Tomorrow

Cleveland Clinic Educational Foundation:

Drugs and Treatment Techniques in Angiograph, February 7-8

Pharmacology and Clinical Effectiveness of Anti-inflammatory Drugs, February 21-22

Sports Medicine, February 28-March 1

Fifth Annual Infectious Disease Conference — Office of Continuing Education (CONMED) of the University of Cincinnati, at the center, February 23.

Sixth Ohio Intercontinental Conference on Diagnostic Medicine — Ohio Academy of Family Physicians; 24 hours of instruction, February 26 through March 11.

March

Studies on the Regulation of Sodium Balance — Veterans Administration Center, 4100 W. Third Street, Dayton 45428, March 2, 2:30 to 4:30 p.m.; lecturer, Jay H. Stein, M.D., Gustav Hirsch Professor of Medicine, at Ohio State; contact, Hassan Mehbod, M.D., at the center.

Fourth Biannual Short Course on Laser Safety — Sponsored by the Medical Laser Laboratory and the Office of Continuing Medical Education (CONMED) of the University of Cincinnati, March 5-9, at the University; contact Laser Safety Course, CONMED, 114 Medical College, Cincinnati 45219; tuition, $325.

Ohio State University College of Medicine, Continuing Medical Education Conferences; for details contact OSU Center for Continuing Medical Education, 410 W. 10th St., Columbus 43210:

Ophthalmology Conference — March 5-6, Center for Tomorrow

Neurochemistry — March 12-15, Center for Tomorrow

Neurology Conference — March 18, Center for Tomorrow

Pediatrics Clinic Day, March 21, at Children's Hospital, Columbus

Dermatology and Allergy — March 28, Center for Tomorrow

General Practice Seminar — March 31-April 1, Center for Tomorrow

Cleveland Clinic Educational Foundation:

Medical Progress and Its Relationship to Dentistry, March 7-8

Advances in Urology, March 14-15

Hodgkins Disease, Leukemia and Lymphoma, March 21-22

Treatment of Neurological Diseases, March 28-29

Eighth Annual Cancer Symposium — Akron City Hospital, 525 E. Market Street, Akron 44309; March 14-15.

Cincinnati VA Hospital Annual Seminar — March 15, at the hospital, 3200 Vine Street, Cincinnati 45220.

Treatment in Psychiatry—Theory and Practice — at the VA Hospital, 1000 Brecksville Rd., Cleveland 44141; cosponsored by the Northwestern Ohio Institute for Continuing Medical Education and the Medical College of Ohio at Toledo; 49 hours, March 26-30.

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ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deticiency. 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence ot hypogonadism.
Cholestatic hepatitis with jaundice and altered liver tunction tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence ot any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in temale patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deticiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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Librium® and (chlordiazepoxide HCl) concomitant use

Librium (chlordiazepoxide HCl) is used as adjunctive antianxiety therapy concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents, diuretics, anticholinergics and antacids.

Antianxiety effectiveness: Demonstrated in a broad range of psychologic and physical dysfunctions; indicated when reassurance and counseling are not enough and until, in the physician's judgment, anxiety has been reduced to tolerable, appropriate levels.

Effect on mental acuity: Usually minimal on proper maintenance dosage.

Safety: An excellent clinical record. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated.

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5-mg, 10-mg, 25-mg capsules up to 100 mg daily in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Supplied: Librium® capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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